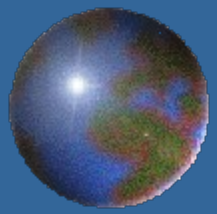


Medical Regulating/Patient Movement

ENS J. George
SWMI POMI Officer

MEDICAL REGULATING COURSE

MISSION:

Provide personnel the fundamental knowledge base and skills necessary to function as a Medical Regulating Control Officer/Patient Evacuation Officer, or on a Medical Regulating Team.

MEDICAL REGULATING COURSE

OBJECTIVE:

Provide an orientation to medical regulating concepts, principles, health service support, medical regulating planning; medical regulating operations; patient movement; medical transportation capabilities; medical regulating reports; management of medical regulating

MEDICAL REGULATING COURSE

SECURITY CLASSIFICATION: Unclassified.

COURSE LENGTH: 2 days, 16 contact hours

DISTRIBUTION OF CONTACT HOURS:
Didactic 12.0
Lab/Practical 4.0

COURSE LOCATIONS: Training provided at various sites by mobile trainers

CLASS CAPACITY: Course is offered 10-12 times each year. Class size averages 30 students.

INSTRUMENTS AND PROCEDURES FOR MEASURING STUDENT PERFORMANCE: Active participation in course exercise denotes successful completion of the course.

REFERENCES

Air Transportation Eligibility, DOD 4515.13-R

Health Service Support in Joint Operations, Joint Pub 4-02

Joint Standard Operating Procedures for Medical Regulating in the Amphibious Objective Area, COMPHIBGRUINST 6320.1B

Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations, Joint Pub 4-02.2

Medical Regulating, DODINST 6000.11

Naval Expeditionary Forces Medical Regulating, NWP 4-02.2

Operational Health Service Support, NWP 4-02

Planning, Operations, and Medical Intelligence, NWP 4-02.3, Part B, Medical Intelligence

SCHEDULE OF EVENTS:

- Medical Regulating Introduction
- Echelons of Care/Triage Categories
- ARG Assets and Capabilities
- Marine Corps Assets and Capabilities
- Reports & Planning
- Communications
- Navy Deployable Medical Units
- Aeromedical Evacuation
- Operational Exercise

MEDICAL REGULATING INTRODUCTION

HEALTH SERVICE SUPPORT

- Primary goal is to assist in conserving the fighting strength of the task force and to rapidly restore the health of sick and injured personnel so they may return to duty as soon as possible.
- Right service, Right place, Right time.
- This goal is evolving as the Marine Corps changes the way they fight the war.
- Medical Regulating is part of HSS.

MEDICAL REGULATING

- A patient management system designed to coordinate the movement of patients from the battlefield through successive echelons of care to a MTF that can provide the appropriate level of care.

- Designed to minimize the effects of wounds, injuries, and disease on unit effectiveness by rapidly evacuating injured personnel.

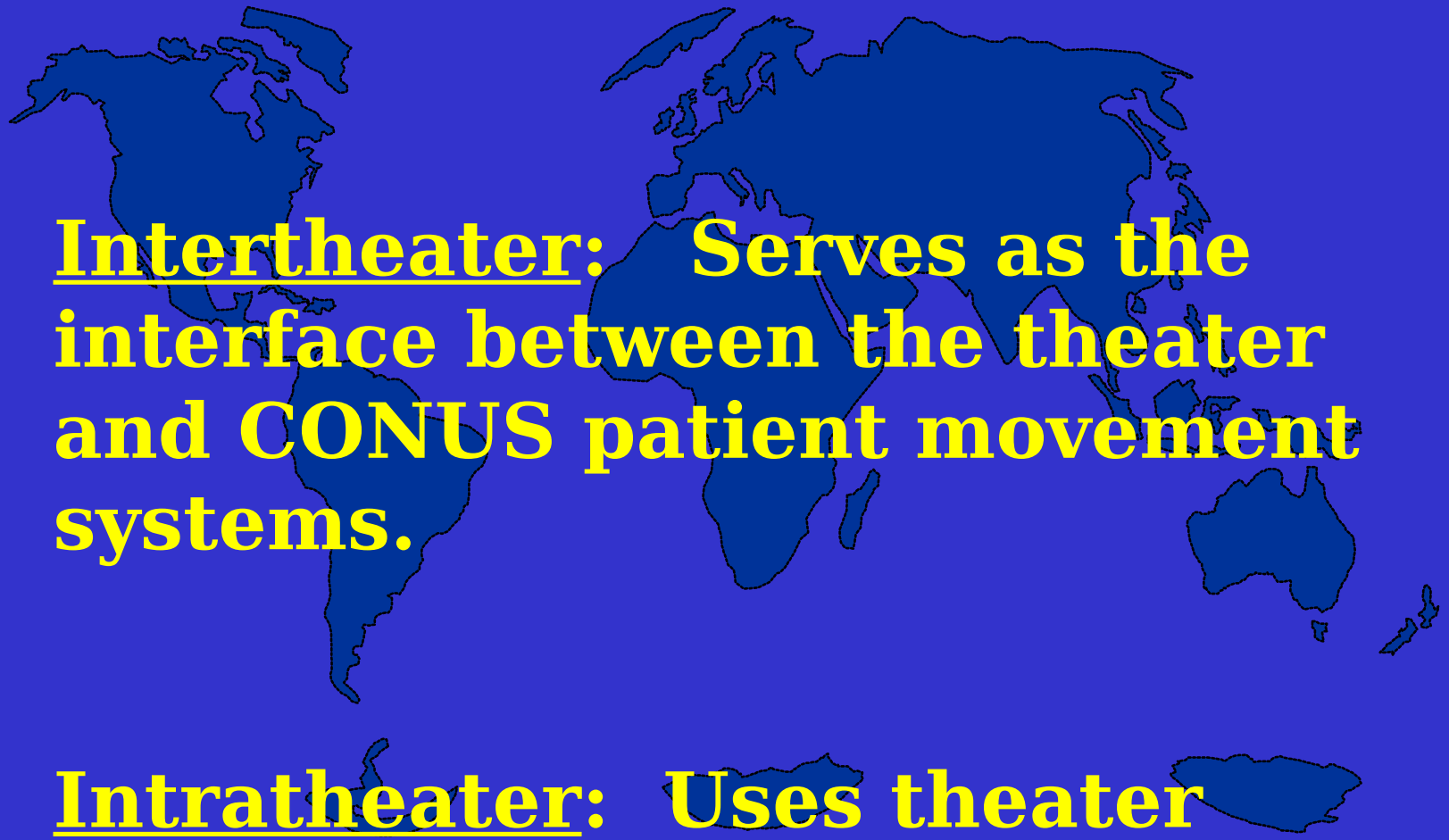
Patient Movement System

- Two components: Med Reg. & Pt. Evac.
- Move Pt.: Point of injury thru HSS System
- Move as far rearward (tactical/clinical needs)
- Avoid increased morbidity and mortality

MEDICAL REGULATING GOALS

- Put the right patient in the right facility at the right time
- Don’t lose any patients
- Know the status of all patients at all times
- Don’t leave them stranded
- Communication

Fundamentals of Patient Movement:



<u>Intertheater</u>: Serves as the interface between the theater and CONUS patient movement systems.

<u>Intratheater</u>: Uses theater resources to evacuate patients to and between medical treatment

Patient Evacuation

- Transportation of wounded, injured, or ill from the immediate AO to HSS facilities and, as required, between HSS facilities.

- **The difference**: Lower levels in the continuum of care, pt's are moved to the nearest HSS facility whereas higher levels are regulated to a designated facility.

The Players!

- Medical Regulating Control Officer (MRCO)
- Medical Regulating Teams (MRT)

- Patient Evacuation Officer (PEO)
- Patient Evacuation Clerks (PEC)

Medical Regulating Control Officer (MRCO)

- MAO or Senior Enlisted
- Medical Reg. Net controller.
- Informs CATF Surgeons of pt. Movement
- Directs & Supervises MedReg Team Ops.

Medical Regulating Team (MRT)

- Navy & Marine Corps Radio Operators
- Assigned to Fixed or Mobile Teams
- Receives & maintains HSS Status within the AOR.
- Coordinates the regulation of casualties
- Within the LF- Pt. Evac. Team.

PEO & PEC's

- When control of medical regulating passes ashore, the LF patient evacuation function is normally established within the DASC and/or co-located with the CSSA, directed and supervised by the LF Patient Evacuation Officer.

PLACEMENT OF REGULATING TEAMS

- Casualty Receiving Ships
- Hospital Ship
- Fleet Hospital
- CV/CVN
- Shock Trauma Platoon
- Surgical Company
- BLT Battalion Aid Station*

* Normally a MC Radio Operator

COMMANDER AMPHIBIOUS TASK FORCE (CATF) SURGEON

- Senior Medical Officer of the Amphibious Task Force
- The Officer in Charge of the Fleet Surgical Team is the CATF Surgeon
- Represents the Commander in all medical matters pertaining to amphibious operations

MEDICAL REGULATING CONTROL OFFICER (MRCO)

- A Medical Service Corps Officer or senior enlisted Hospital Corpsman located on the primary control ship who controls and coordinates the seaward evacuation of casualties in the amphibious objective area.
- Directs and supervises the Medical Regulating Team.
- Collocated with CATF Surgeon

DUTIES OF THE MRCO

- Determine the need and location for all Medical Regulating Teams
- Develop the loading plan for all units in the Task Force
- Develop procedures for transporting patients between Echelons of Care
- Establish procedures for radio and message traffic

DUTIES OF THE MRCO (cont.)

- Maintain liaison between the CATF Surgeon and all units on the Medical Regulating Net
- Maintain facility status boards

MEDICAL REGULATING TEAM (MRT)

- Generally 4 - 5 personnel
- Navy Hospital Corpsmen (8424/0000)
- Marine Corps Radio Operators
- Assigned to mobile or fixed MTF’s
- Responsible to the MRCO
- Maintain and receive MTF status and capabilities, coordinate regulation of casualties within the AOA

PLACEMENT OF REGULATING TEAMS

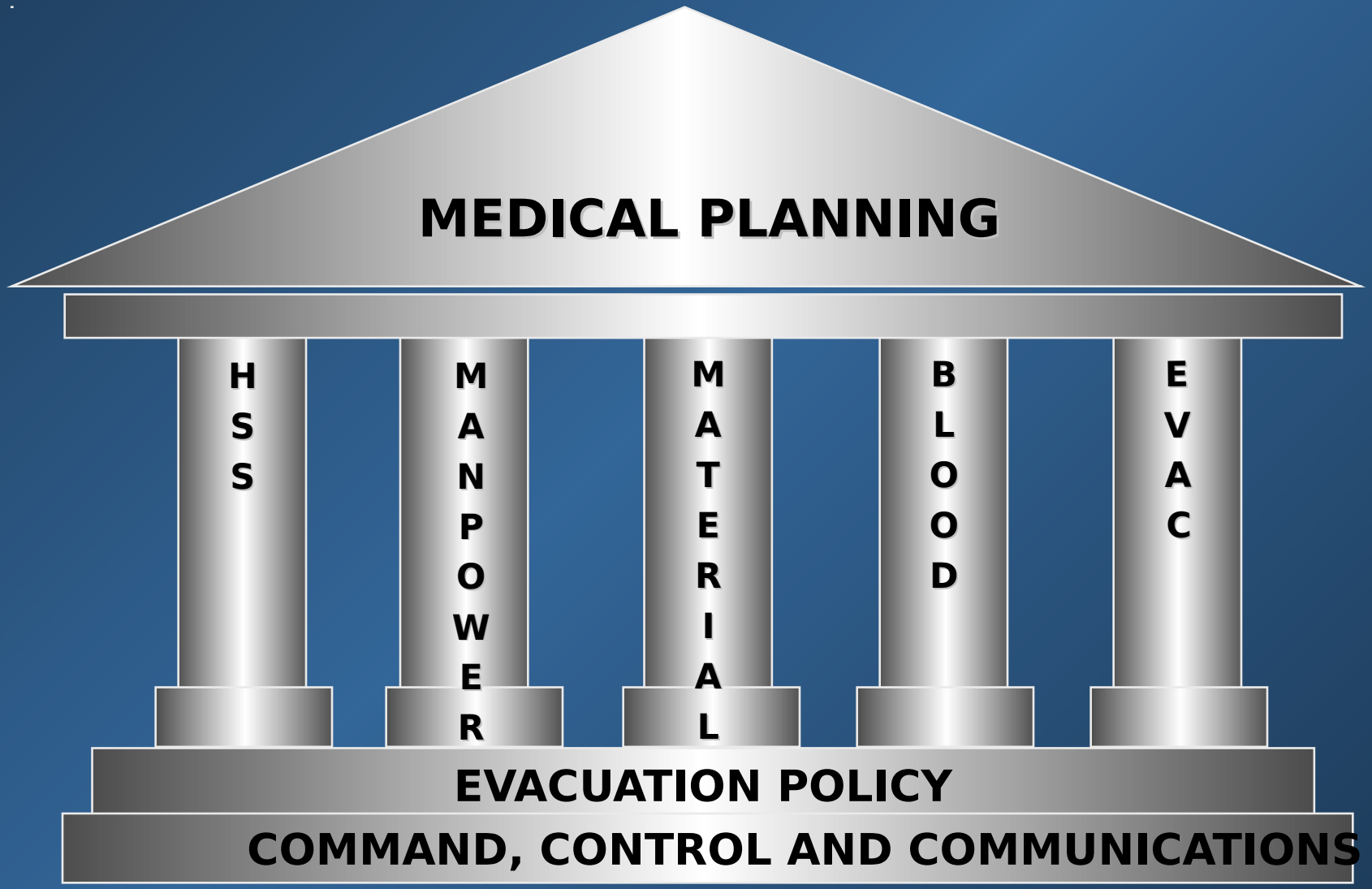
- Casualty Receiving Ships
- Hospital Ship
- Fleet Hospital
- CV/CVN
- Shock Trauma Platoon
- Surgical Company
- Landing Force
- Battalion Aid Station*

* Normally a MC Radio Operator

MEDICAL REGULATING VS. AEROMEDICAL EVACUATION

- Medical Regulating
  - Patient movement and control process
  - Reserves hospital bed by specialty for the patient before evacuation
  - Ensures appropriate staff is available before evacuation
- Aeromedical Evacuation
  - Movement of patients, under medical supervision, by air, from one echelon of care to another
  - Provides limited care in transit

MEDICAL REGULATING PLANNING



HEALTH SERVICE SUPPORT

- The various treatment capabilities of the health service support system in the AOA. Battalion Aid Stations, Shock Trauma Platoons, Surgical Companies, CRTS's, Fleet Hospitals, Hospital Ships, OCONUS, and CONUS.
- In particular, the type and number of beds available to support the patient load.

MANPOWER

- The number of medical and non-medical personnel assigned to each unit.
- This includes determining the specialty mix of personnel, corpsman to doctor ratios, and other technical, ancillary and support manpower required.

MATERIAL

- The total amount of medical supplies and equipment needed to support the operation must be calculated.
- The amount and type of consumables available at each unit and echelon of care.
- Must consider material distribution, dispersion and re-supply.

BLOOD

- Organizational, operational, and logistical considerations about fluid and blood product requirements at each echelon of care.
- Ensure each unit understands the blood status reporting requirements and walking blood bank procedures
- Identify the Armed Services Blood Program Office in the AOA.

ECHELONS OF CARE

- What are the echelons of medical care the USN and USMC provide during war time?
- What treatment capability is available at each level?
- What organizations provide each level of treatment?

ECHELONS OF CARE

- Casualties are moved, evaluated, and treated through different echelons of the health service support system from the point of injury to the facility that has the necessary capabilities, personnel and time to provide treatment.

EVACUATION BETWEEN ECHELONS

- Generally, the component commands are responsible for casualty evacuation from point of injury through successive echelons of care. Evacuation is performed by the next higher echelon of care going forward and evacuating rearward.

CONTINUUM OF CARE

- Defines the Health Service Support System for the ATF.
- Designed to provide healthcare from the point of injury to the level of care that constitutes full treatment.
- Allows for progression of care from highly mobile units to the more capable, sophisticated, less mobile units in the rear.

1st Echelon of Care

- First Aid/Emergency Medical Care
  - Basic first aid
  - Self aid and buddy aid
  - Establish and maintain an airway
  - Control bleeding
  - Cardiac support
  - Treatment or prevention of shock
  - Splints, bandages, and IV fluids

2nd ECHELON OF CARE

- Initial Resuscitative Care
  - Medical and surgical resuscitation
  - Care rendered to save life and limb
  - Stabilize the patient’s condition for transport
  - Lowest level at which blood and blood products are available

3rd ECHELON OF CARE

- Resuscitative Care
  - Higher Level of Surgical and Medical Resuscitative Capability
  - Treatment is adapted to condition of patient
  - Located in an environment with a low level of threat from enemy action

4th and 5th ECHELONS OF CARE

- 4th - Definitive Care
  - Definitive phase of treatment
  - Precisely adapted to condition of patient
  - Comprehensive medical and surgical care
- 5th - Convalescent, Restorative and Rehabilitative Care
  - Minimal care
  - Increasing physical activity

ECHELON OF CARE PROVIDERS

- 1st Echelon
  - Marines
  - Company Corpsmen
  - Battalion Aid Station
- 2nd Echelon
  - Shock Trauma Platoon
  - Surgical Companies
  - Casualty Receiving and Treatment Ships
  - CV and CVN’s

ECHELON OF CARE PROVIDERS

- 3rd Echelon
  - Fleet Hospitals
  - Hospital Ships
- 4th Echelon
  - Overseas and small CONUS MTF’s
- 5th Echelon
  - Large CONUS MTF’s
  - Veterans Affairs Medical Centers
  - National Disaster Medical System

TRIAGE

- Incoming patients are classified by level and immediacy of required treatment.
- Triage is a dynamic process.
- Many factors affect the triage category.
- Any significant change can call for a reassessment of the patient’s condition and triage category.
- Medical regulating relies on continuous practice of effective patient triage.

TRIAGE CATEGORIES

- Immediate Treatment - Emergency life saving resuscitation/surgery.
- Delayed Treatment - Stable patients that need time consuming major surgery.
- Minimal Treatment - Patients with relatively minor injuries, can sometimes care for themselves.
- Expectant Treatment - Serious multiple injuries with a low chance of survival.

IMMEDIATE TREATMENT (GROUP T1)

- Emergency life saving resuscitation and surgery. Procedures should not be time consuming, only patients with a high chance of survival.
  - Respiratory Obstruction
  - Accessible Hemorrhage
  - Emergency Amputation
- Normally treated at Echelon 2 or 3 facility.

DELAYED TREATMENT (GROUP T2)

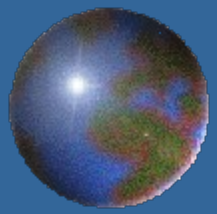
- Time consuming major surgery whose condition permits delayed treatment.
  - Large Muscle Wounds
  - Fractures of Major Bones
  - Intra-Abdominal and/or Thoracic, Head, and Spinal Injuries
  - Uncomplicated Major Burns
- Normally treated at Echelon 2 or 3 facility.

MINIMAL TREATMENT (GROUP T3)

- Patient with relatively minor injuries who can care for themselves or can be helped by lesser trained personnel.
  - Minor Lacerations
  - Sprains and Strains
  - Abrasions
  - Minor Burns
- Can be treated by any Echelon facility.

EXPECTANT TREATMENT (GROUP T4)

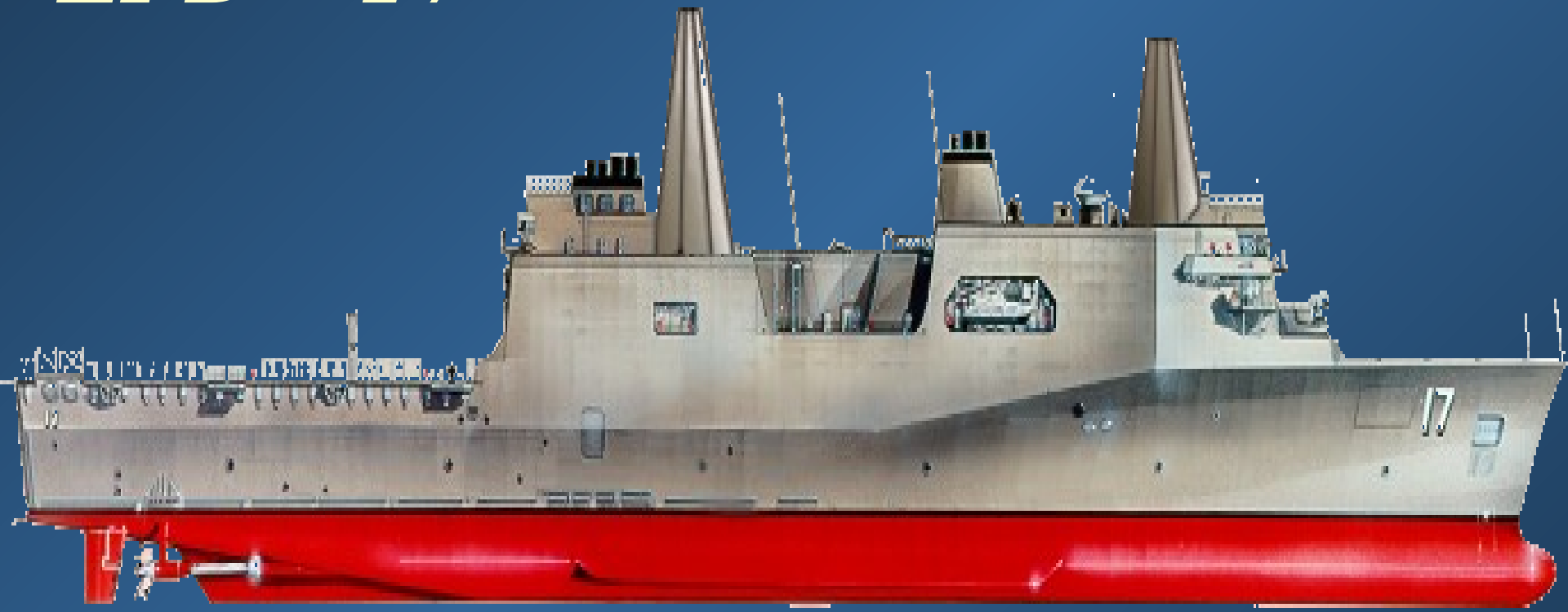
- Serious multiple injuries, time consuming treatment, and a low chance of survival. Treat all other categories of patients first.
  - Severe Multiple Wounds
  - Severe Head or Spinal Wounds
  - Widespread, Severe Burns
  - Large Doses of Radiation
- Normally treated at an Echelon 3 facility



The Amphibious Readiness Group

Show the presentation

LPD - 17



LHA CLASS PLATFORM

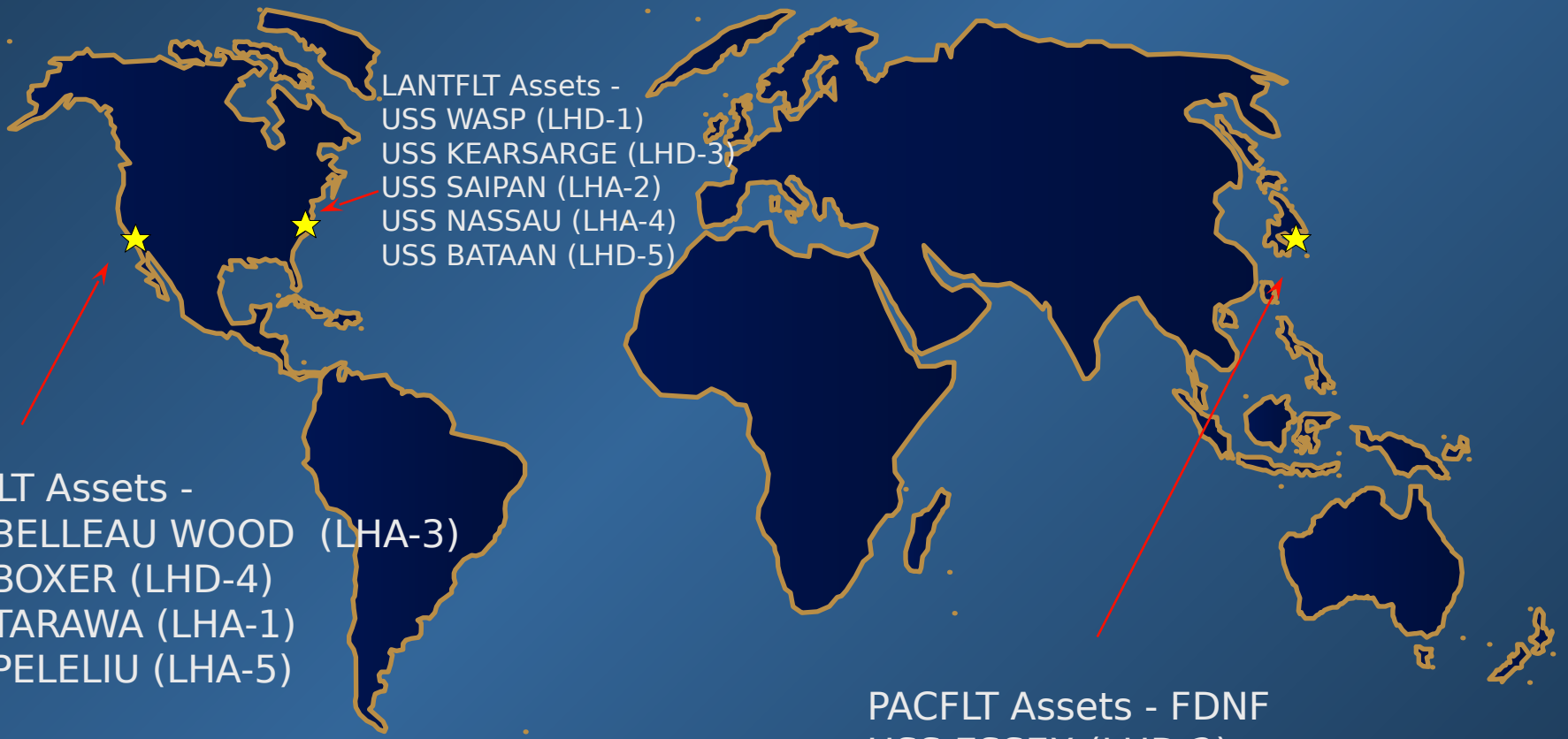
AMPHIBIOUS ASSAULT SHIPS - LHD/LHA

- 4 Operating rooms
- 15 ICU beds
- 45 Ward beds
- Must be augmented by MAP Personnel & FST to have full surgical capability

AMPHIBIOUS ASSAULT SHIPS - LHD/LHA (cont)

- 1 Officer, 19 enlisted personnel (ship's co)
- Augmented by 100 additional personnel
  - 16 from Fleet Surgical Team
  - 84 from Medical Augmentation Program
- Laboratory
- X-ray (1 fixed, 1 portable)
- Blood banking (2 reefers)
- Pharmacy

CRTS HOMEPORTS



FLEET SURGICAL TEAM (FST)

- Provides one general surgical team and a medical regulating team. 16 People.
- CINC Asset - peacetime and wartime to meet routine deployment requirements.
- Seven FST’s, 3 on each coast, 1 fwd deployed.
- Normally deployed on a CRTS.
- OIC is CATF Surgeon for Task Force.
- Provides the Medical Regulating Control Officer.

FST STAFFING

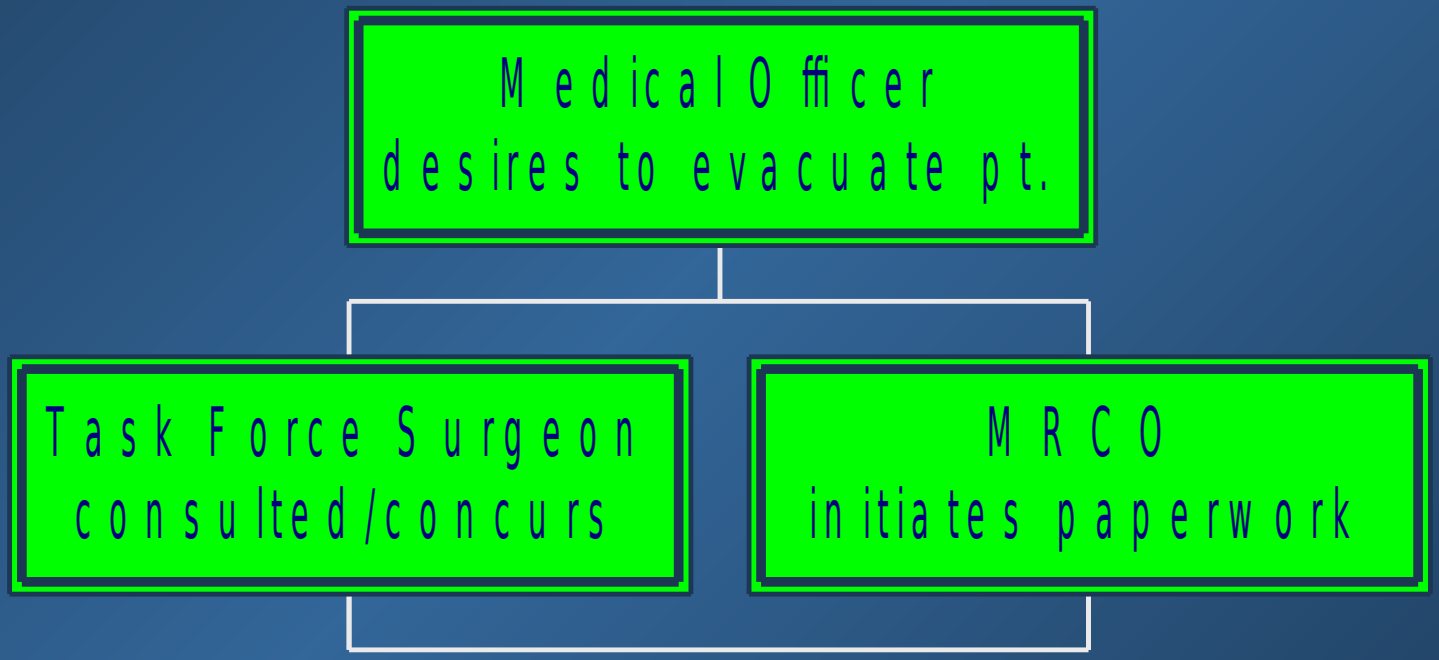
- CATF Surgeon - CAPT, MC
- General Surgeon - MC
- Family Practitioner - MC
- Anesthetist - MC or NC
- Perioperative Nurse - NC
- Charge Nurse - NC
- Medical Regulator - MSC
- General Duty Hospital Corpsman - 5
- Operating Room Technicians - 2
- Laboratory Technician - 1
- Respiratory Therapy Technician - 1

Shipboard MEDEVAC

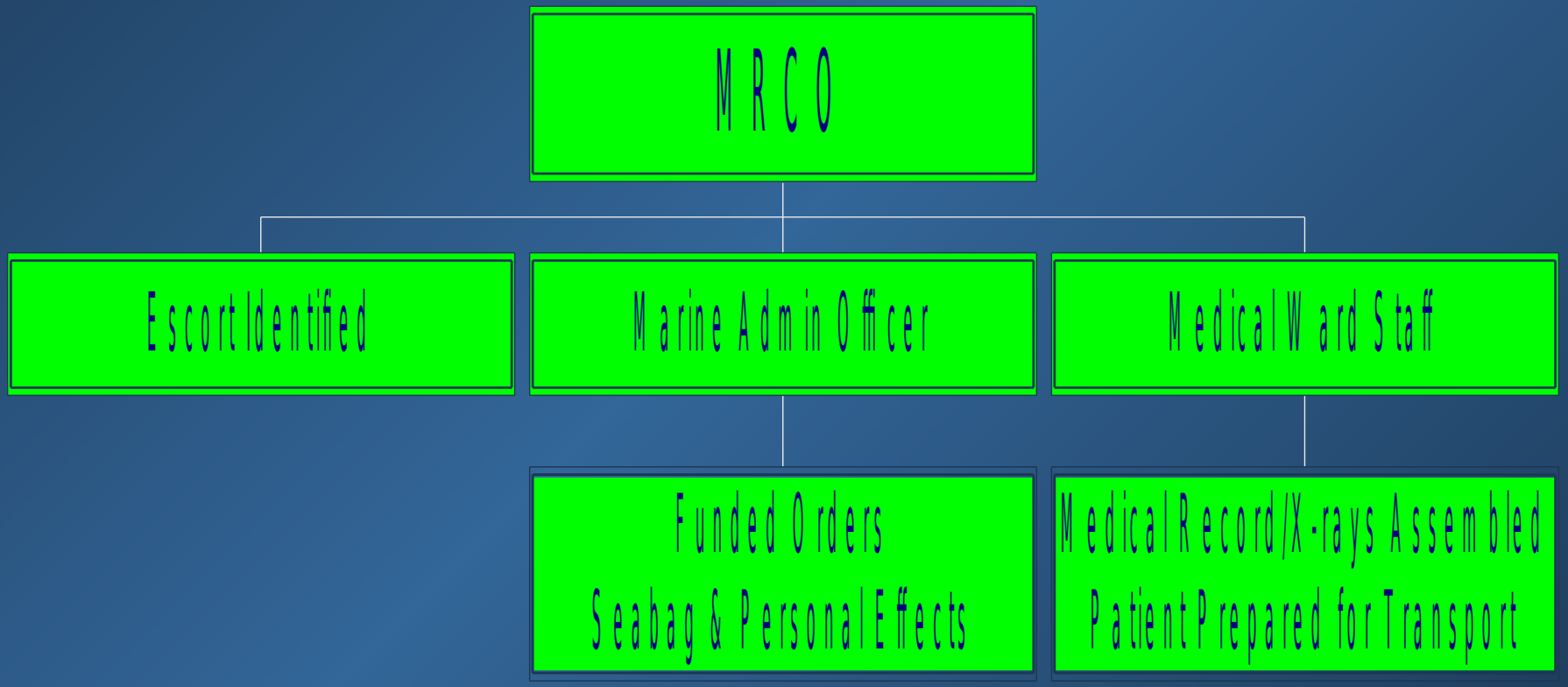
PT Movement “At Sea”

- You are the ship with appropriate clinical specialists
- Movement is usually accomplished by air
- Weigh the dangers
- Alternatives must be considered (e.g. radio)
- Escort when required (non-medical preferred)

Shipboard MEDEVAC



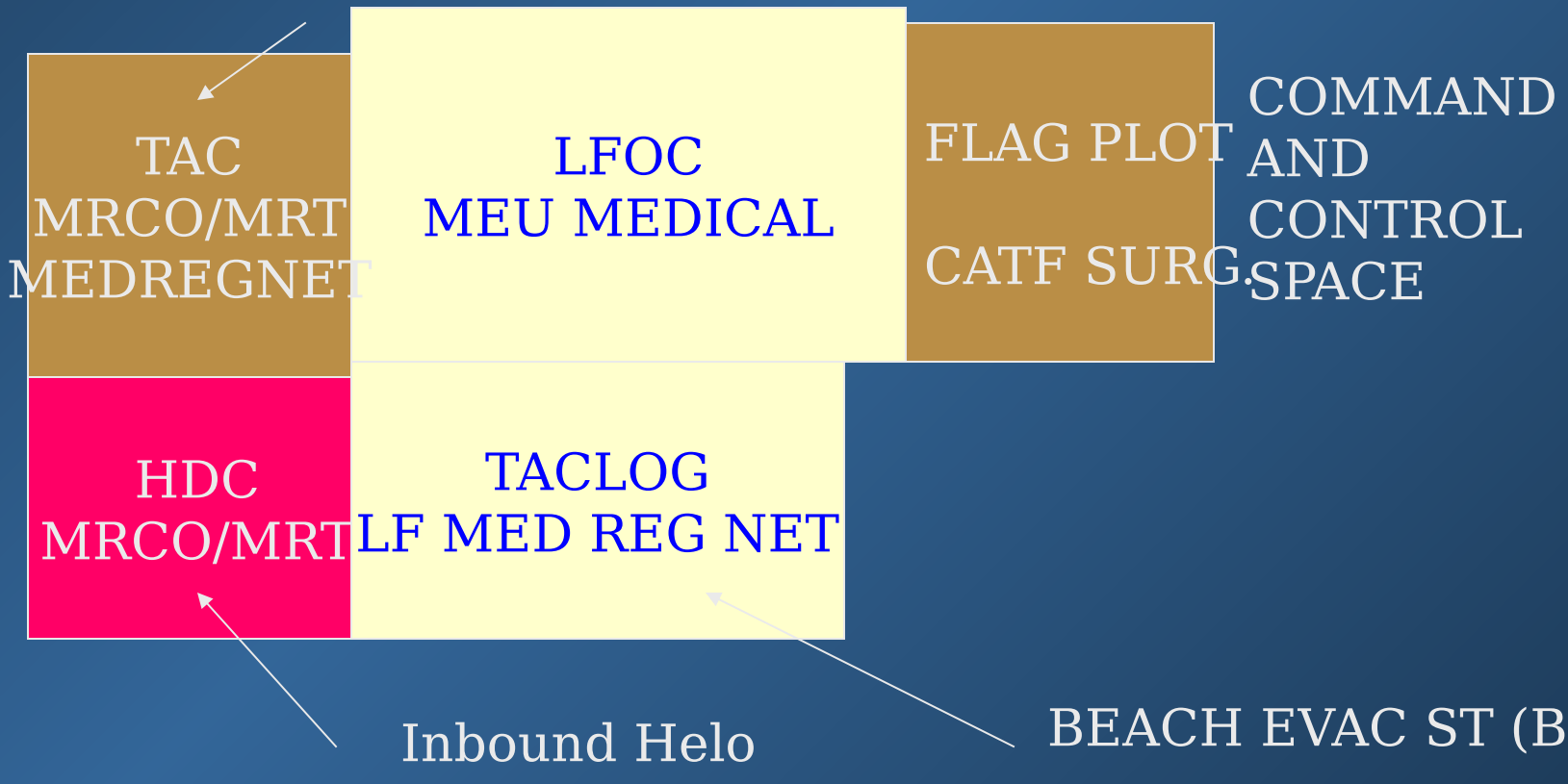
Shipboard MEDEVAC



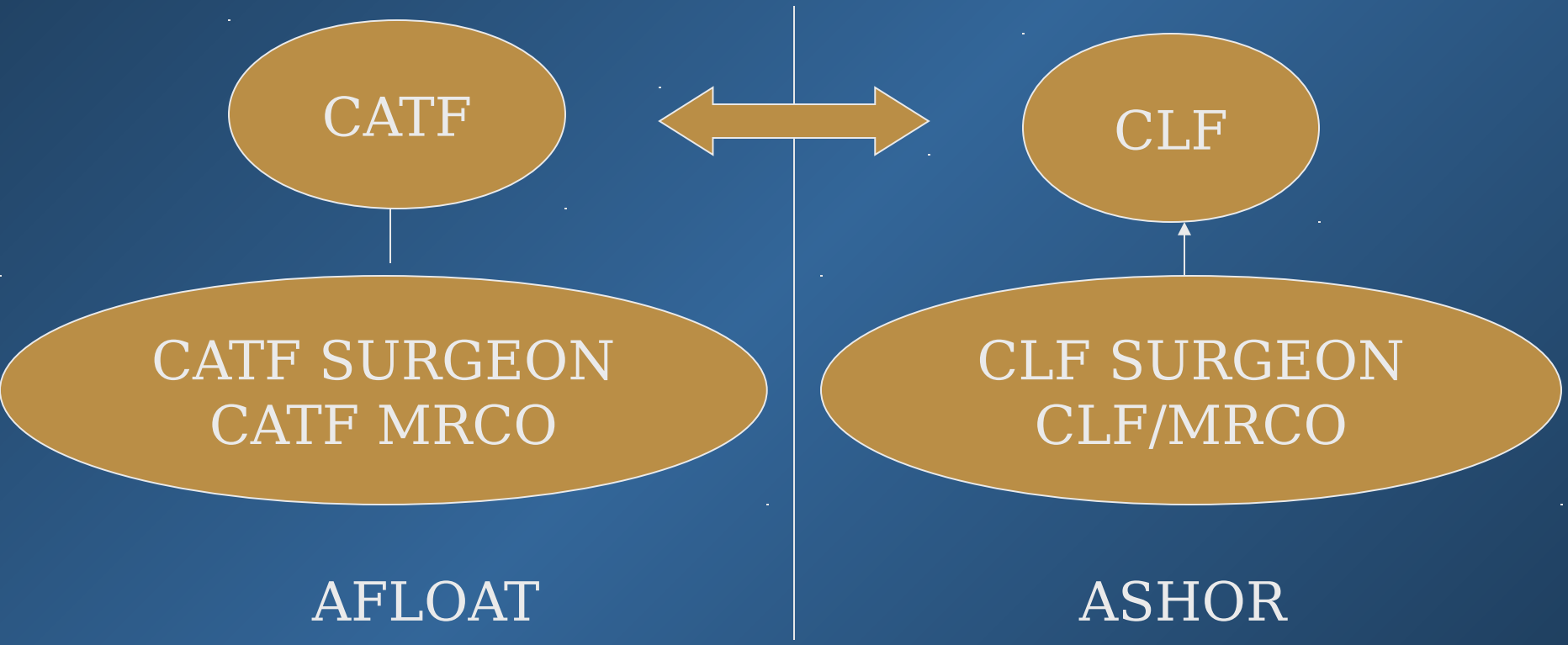
TASK FORCE MEDICAL REGULATING CONTROL CENTER

General Purpose Amphibious Assault Ship (WASP CLASS)

Direct Air Support Center (DASC)

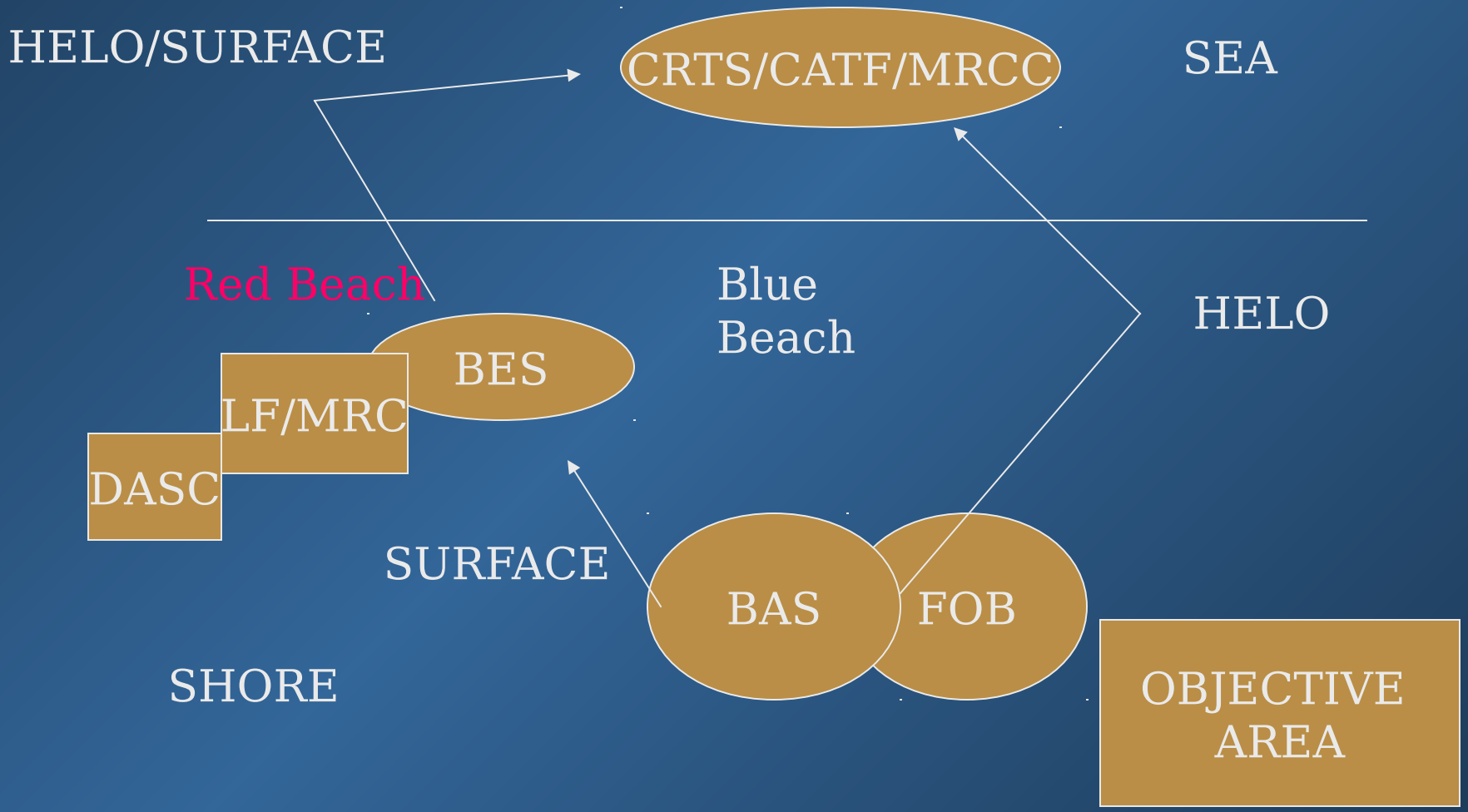


MEDICAL REGULATING AMPHIBIOUS OPERATIONS



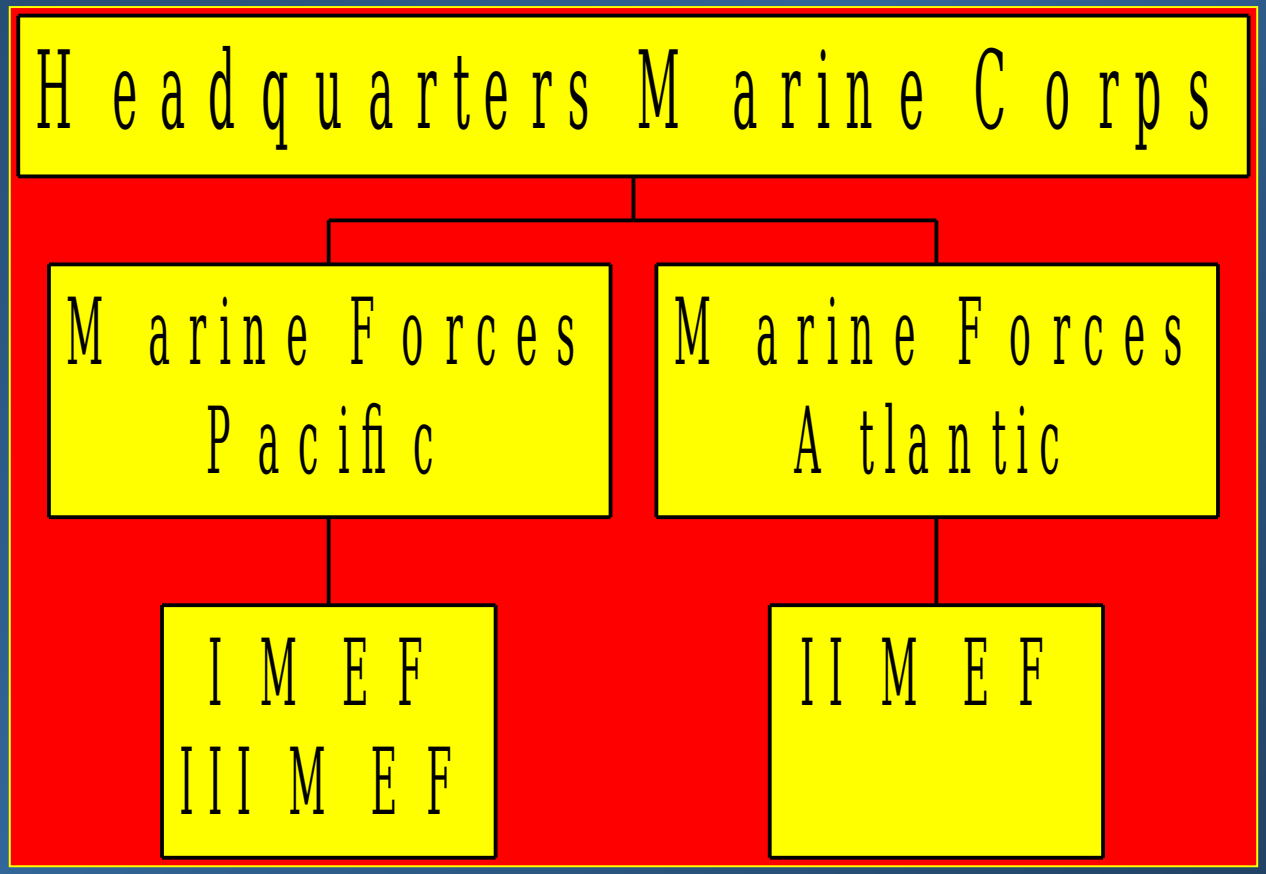
CO-EQUAL ORGANIZATIONS

Landing Force Medical Regulating Center

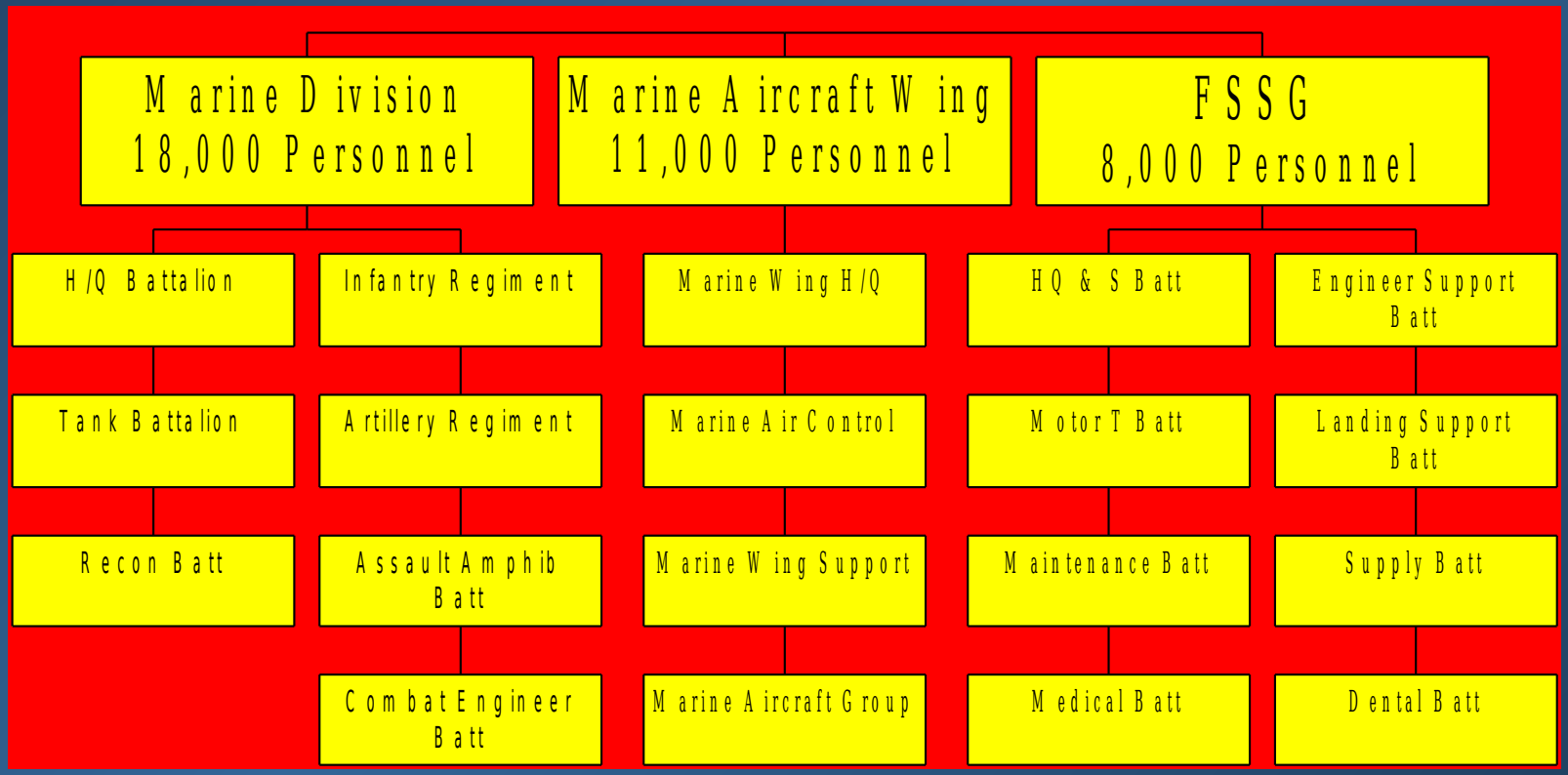


USMC DEPLOYABLE MEDICAL UNITS

MARINE CORPS ORGANIZATION



MARINE EXPEDITIONARY FORCE



MARINE AIR GROUND TASK FORCES

- Marine Expeditionary Force (MEF)
  - 30,000 - 50,000 personnel
  - 60 days of support in all out war
- Marine Expeditionary Brigade (MEB)
  - 16,500 personnel
  - 30 days support in regional contingency
- Marine Expeditionary Unit (MEU)
  - 2,000 personnel
  - 15 days support in localized strike

MARINE EXPEDITIONARY UNIT SPECIAL OPERATIONS CAPABLE (MEU SOC)

- A MEU that is trained and designated as Special Operations Capable
  - Tactical Recovery of Aircraft and Personnel
  - Close Quarters Battle
  - Maritime Interdiction Operations
  - Military Operations in Urban Terrain
  - Specialized Demolition Operations
  - Non-Combatant Evacuee Operations
  - Humanitarian and Civil Assistance

CURRENT PARADIGM - FORCE MULTIPLIER

- Conservation of combat power
- Preventive medicine - safeguard the health

  of the unit
- Continuum of Care - effective care of the

  sick and injured
- Medical evacuation - prompt and

ECHELON 1 PLATFORMS

- First aid trained Marines
- Company Corpsman
  - 44 HM’s per Battalion
- Battalion Aid Station
  - 2 MC, 21 HM’s

ECHELON 2 PLATFORMS

- Shock Trauma Platoon
  - 8 STP's per Med Bn
  - ATLS intensive
  - Highly mobile
  - Stabilization Section
  - Collecting/Evacuation Section
- Surgical Company
  - 3 per Med Bn
  - 3 OR's, 60 beds per Co

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Battlefield Casualties

MEDEVAC Field Request

- 9 Line MEDEVAC Request
- Lift of Opportunity
- MEDREG Net
- TAR/HAR Net

MEDEVAC REQUEST

1. LOCATION
2. MARKINGS
3. FREQUENCY/CALLSIGNS
4. SECURITY AT SITE
5. TOTAL # OF PT'S
6. # OF PT'S BY TYPE
7. PICK UP TIME
8. NATIONALITY / STATUS
9. TYPE OF WOUND, INJURY OR ILLNESS, CBR

Lift of Opportunity

Lift of Opportunity

Selecting Mode of Transport

- Tactical situation
- Availability of assets
- Patient's condition
- Location of receiving unit

Modes of Transport

- Ground transportation
- Sea evacuation
- Aeromedical evacuation *

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Inside of LCAC PTM

LCAC Personnel Transport Module (PTM)

- 4-6 hours to fully construct
- 145 walking wounded
- 54 patients on litters
- **Lift of Opportunity**

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MEDICAL REGULATING REPORTS

A Combat Typist's Dream

MEDICAL REGULATING REPORTS

- CATF Surgeon establishes reporting requirements for all units in the ATF
- Additional requirements are established by the CINC through the Fleet Surgeon
- Daily Reports are submitted per the OPLAN to the CATF Surgeon and CINC
- TRUTH IN ADVERTISING

MEDICAL REGULATING REPORTS (cont.)

- Units report their status every 24 hours.
- During periods of increased operations, updates will be submitted as changes occur, can be up to every six hours.
- Reports can be submitted via voice, flashing light, message, e-mail, SALTS, or semaphore, etc. Voice reports must be followed by message reports

MESSAGE REPORTS AND REQUESTS

- Medical Joining Report
- Facilities Spot Status Report
- Casualty Evacuation Request
- Blood Status Report/Request
- Medical Census Report

MEDICAL JOINING REPORT

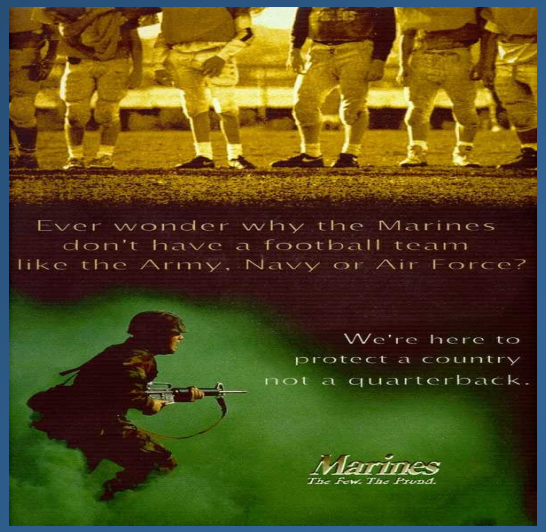
FM: REPORTING UNIT
TO: CTF 378//NO1M//
SUBJ: MEDICAL JOINING REPORT
REF A: OP ORDER OR OP PLAN
1. NUMBER OF DEDICATED OPERATING ROOMS
2. NUMBER OF OTHER OPERATING AREAS EQUIPPED WITH SUITABLE EQUIPMENT NEEDED FOR PERFORMING BASIC SURGICAL PROCEDURES
3. NUMBER OF FIXED X-RAY MACHINES
4. NUMBER OF PORTABLE X-RAY MACHINES
5. NUMBER OF REFRIGERATORS SUITABLE FOR WHOLE BLOOD STORAGE
6. NUMBER OF BLOOD UNITS ONHAND BY A, B, O, AND RH FACTOR
7. NUMBER OF WALKING BLOOD DONORS BY A, B, O, RH FACTOR
8. NUMBER OF ICU BEDS AVAILABLE
9. NUMBER OF OTHER BEDS AVAILABLE
10. NUMBER OF OVERFLOW BEDS AVAILABLE
11. MANPOWER BREAKDOWN BY NOBC, NEC FOR ALL PERSONNEL

FACILITIES SPOT STATUS REPORT

FM: REPORTING UNIT
TO: JOINT TASK FORCE MRCO
SUBJ: FACILITIES SPOT STATUS REPORT AS OF HHHH, DD MMM YY
ALPHA: OPERATING BEDS
BRAVO: BEDS OCCUPIED
CHARLIE: MAJOR OPERATING ROOMS
CHARLIE ONE: PATIENT BACKLOG
CHARLIE TWO: HOURS BACKLOG
DELTA: MINOR OPERATING ROOMS
DELTA ONE: PATIENT BACKLOG
DELTA TWO: HOURS BACKLOG
ECHO: PATIENTS READY FOR LATERAL TRANSFER
FOXTROT: PATIENTS READY FOR EVACUATION OUT OF AOA
GOLF: REMARKS

CASUALTY EVACUATION REQUEST

Marine Corps


Ever wonder why the Marines don't have a football team like the Army, Navy or Air Force?
We're here to protect a country not a quarterback.
Marines
The Few. The Proud.

ARG

BLOOD STATUS REPORT

FM: REQUESTING UNIT
TO: TASK FORCE MRCO/BSU
SUBJ: BLOOD STATUS/REQUEST
ALPHA ONE: EFFECTIVE DATE OF REPORT
ALPHA TWO: UNIT/FACILITY REPORTING
ALPHA THREE: LOCATION OF UNIT
BRAVO ONE: NUMBER OF UNITS ONHAND
BRAVO TWO: EXPIRATION DATE BY A, B, O, AND RH FACTOR
CHARLIE ONE: TOTAL UNITS TRANSFUSED
CHARLIE TWO: TOTAL UNITS EXPENDED
DELTA ONE: ESTIMATED NUMBER UNITS REQUIRE NEXT 10 DAYS
DELTA TWO: ESTIMATED NUMBER UNIT BY A, B, O, RH NEXT 10 DAYS
DELTA THREE: DESIRED DELIVERY DATE
DELTA FOUR: DESIRED DELIVERY DESTINATION
DELTA FIVE: RECEIVING OFFICIAL AT DESTINATION

MEDICAL CENSUS REPORT

FM: REPORTING UNIT
TO: CATF SURGEON
SUBJ: MEDICAL CENSUS REPORT FOR MRCO
ALPHA: UNIT REPORTING
BRAVO: LOCATION OF UNIT
CHARLIE: EFFECTIVE DATE OF REPORT
DELTA: TOTAL OPERATING BEDS
ONE: ICU BEDS TWO: INTERMEDIATE CARE BEDS
THREE: MINIMAL CARE BEDS
ECHO: TOTAL ADMISSIONS BY SERVICE/CIVILIAN/POW
FOXTROT: TOTAL UNOCCUPIED BEDS
ONE: ICU BEDS TWO: INTERMEDIATE CARE BEDS
THREE: MINIMAL CARE BEDS
GOLF: TOTAL PATIENTS REMAINING BY SERVICE/CIVILIAN/POW
HOTEL: TOTAL PATIENTS RETURNED TO DUTY
INDIA: TOTAL PATIENTS EVACUATED

MEDICAL CENSUS REPORT (cont)

JULIET: TOTAL DEATHS IN FACILITY BY SERVICE/CIVILIAN/POW
KILO: PATIENTS REQUIRING EVACUATION
ONE: PATIENTS READY FOR EVACUATION NOT PREVIOUSLY REPORTED
TWO: PATIENTS READY FOR EVACUATION PREVIOUSLY REPORTED, BUT NOT EVACUATED
LIMA: UNUSUAL INCIDENCE OF DISEASE OR INJURY
MIKE: TOTAL OUTPATIENT VISITS DURING PERIOD
NOVEMBER: UNRESOLVED MEDICAL LOGISTICS PROBLEMS
OSCAR: AMOUNT OF BLOOD USED BY TYPE

STATUS BOARDS

- Consolidated Joining Report Board
- Facilities Spot Status Board
- Medical Regulating Status Board
- Blood Status Board
- Patient Status Board

JOINING REPORT STATUS BOARD

REPORTING UNIT:								
1. Number of Dedicated Operating Rooms								
2. Number of Minor Operating Rooms								
3. Number of Fixed X-ray Units								
4. Number of Portable X-ray Units								
5. Number of Blood Units On Hand								
6. Number of Blood Reefers and Capacity								
7. Number of Walking Blood Donors								
8. Number of ICU Beds Available								
9. Number of other Sickbay Beds								
10. Number of Overflow Beds								
11. Number of MC/DC/MSC/NC by NOBC								
12. Number of HM/DT by NEC								
13. Embarked Medical Personnel by Unit, NEC, and NOBC								

FACILITY SPOT STATUS BOARD

Facility Status as of: hhhh, dd mmm yy								
Unit Call Sign:								
A. Operating Beds								
B. Beds Occupied								
C. Major Operating Rooms								
1. OR Backlog - Patients								
2. OR Backlog - Hours of Surgery								
D. Minor Operating Rooms								
1. OR Backlog - Patients								
2. OR Backlog - Hours of Surgery								
E. Patients Ready for Evacuation								
F. Patients Evacuated out of AOA								
G. Remarks								

MEDICAL REGULATING STATUS BOARD

UNIT	BEDS/BEDS OCCUPIED	MED	SURG	PSYC	ORTH	OB	PEDS	ACTIVE REQUESTS FOR PATIENT MOVEMENT: URGENT/PRIORITY/ROUTINE
	/							/ /
	/							/ /
	/							/ /
	/							/ /
	/							/ /
	/							/ /

Returned to Duty		Remarks/Notes
Died of Wounds		
Intratheater Evacuations		
Intertheater Evacuations		
Total		As of 0001, DD MMM YY

BLOOD STATUS BOARD

Actual Blood Status as of dd mm yy								
Reporting Unit								
A - Positive								
A - Negative								
B - Positive								
B - Negative								
O - Positive								
O - Negative								
AB - Positive								
AB - Negative								
Number of Walking Blood Donors by A, B, O/RH Types								
Reefers								
Total Units								

CATF SURGEON'S PATIENT STATUS BOARD

Unit	Pt.#	DX	Triage Cat	Blood	FT/D	F
FHP	K-4198	Leg FX	DEL	0	OC/3	
KSG	C-9102	GSW	IMM	2/DAY	CFT/2	OC/
WSP	D-3245	3d BRN	IMM	0	FHP/3	OC

PT
INJURY / CATEGORY
LOCATION
PT
INJURY / CATEGORY
LOCATION
18
19
20
21
22
23
24
SEP 22 2000

Triage Categories

- Immediate (red)

  T1
- Delayed (yellow)

  T2
- Minimal (green)

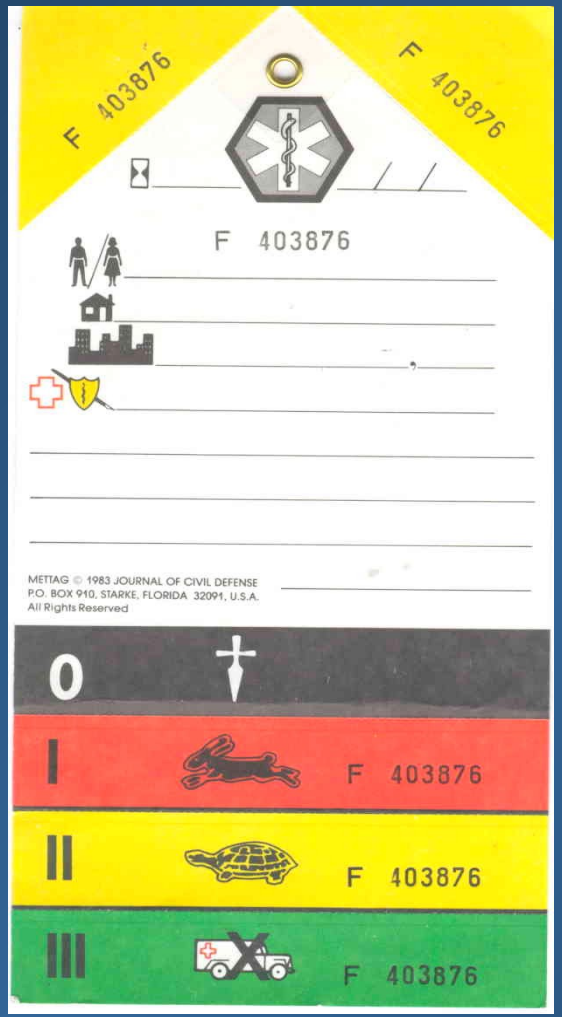
  T3
- Expectant (black)

  T4
- Deceased

  T5

- require emergency life-saving resuscitation/surgery
- condition permits delay in treatment without life endangerment
- can care for themselves or require minimum trained assistance
- require time-consuming treatment with low chance of survival
- DOW/KIA

Casualty Tag



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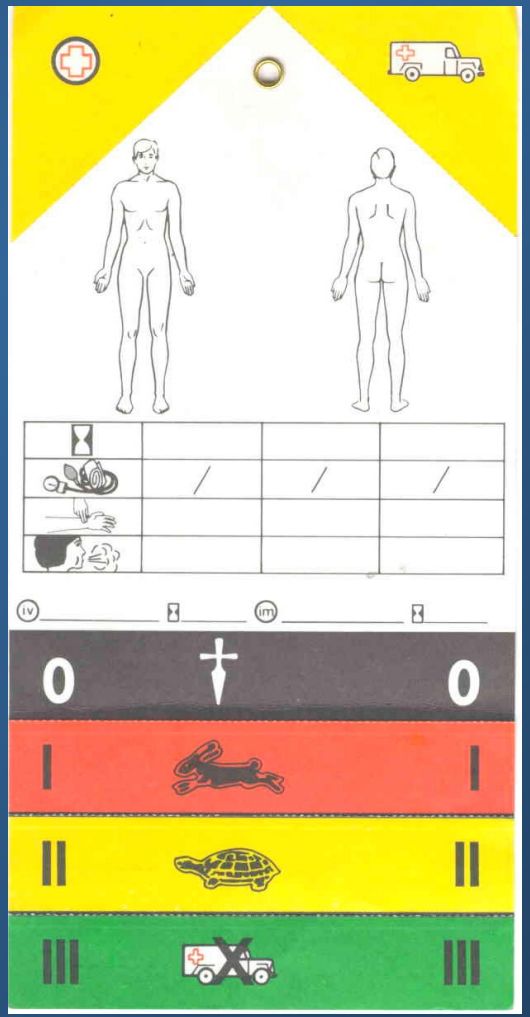
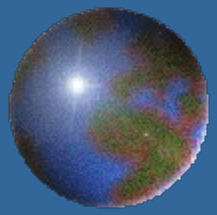


BACK



Medical Planning

For the OPLAN

Show Planning Presenta

MEDICAL REGULATING PLANNING

- Conformity - Integration into the OPLAN.
- Proximity - As close to the AOA as possible.
- Flexibility - Shift resources to meet requirements.
- Mobility - Rapid movement to support combat force.
- Continuity - Seamless flow through echelons of care.

EVACUATION

- Availability and capability of air and land assets? Who can authorize their use? How can they be configured or reconfigured for use.
- Casualty rates, availability and capability of MTF’s, and the means of patient transport require detailed planning and coordination.

THEATER EVACUATION POLICY

- MAXIMUM NUMBER OF DAYS A CASUALTY CAN BE HELD IN THEATER FOR TREATMENT.
- Established by the SEC DEF with advice from JCS and recommendation of CINC.
- Defined in OPLAN for entire Task Force.

THEATER EVACUATION POLICY

- Patients who can not return to duty within that time are immediately evacuated to another theater or CONUS for treatment, providing that evacuation will not exacerbate the patient's condition.
- Evacuation policy must be fluid. It is feasible that it could change on a daily or hourly. Can be different between echelons of care.

FACTORS INFLUENCING EVACUATION POLICY

- Nature of Tactical Operations - quick strike or heavy build-up.
- Anticipated Casualty Rates
- Evacuation Means - Number and type
- Availability of Replacements
- Availability of Theater Resources
- Timeliness - Amount of time allowed for build-up.

LONG EVACUATION POLICY - 30 Days

- Greater accumulation of patients and subsequent demand for a larger HSS.
- Increases HSS material, maintenance and non-medical logistics support.
- Decreases requirements for ready replacements, greater proportion of RTD, decreases loss of experienced manpower.

SHORT EVACUATION POLICY - 7 Days

- Fewer hospital beds required in theater.
- Greater number of beds required outside the theater.
- Greater demand for intertheater evacuation assets.
- Increases the requirement for replacements.

Theater Evacuation Policy

- Establishes maximum number of non-effective days casualties held within theater treatment.
- MO determines RTD status
- RTD does meet prescribed period, evacuation occurs based on clinical and tactical situation.

Theater Evacuation Policy

- Decided early
- Established by SECDEF (initially)
- Advice from J/CS
- Unified CINC’s recommendation

Determining Factors

- Nature of tactical operations
- Number and types of patients
- Means of evacuation
- Availability of replacements
- Availability of theater resources
- Timeliness

What does this mean?

- Medical Officer
  - Treatment
  - Recovery
  - RTD within X Days
  - RTD exceeds X Days
  - Evacuation
- Medical Planner
  - Longer policy, increased HSS
  - Shorter policy, increased evac assets

Medical Regulating Appendix to Annex Q

- Detailed to provide sufficient support
- HSS assets clearly identified
- CRTS designation
- Loading plans for HSS development
- Communication Plan (MRN) & C2
- Air plans (appropriate air control agencies)

Medical Regulating Appendix to Annex Q (Cont -)

- HSS personnel & equip identified/obtaining
- Theater Evacuation Policy
- Patient evacuation (all levels of HSS)
- Joint/Host Nation MedReg coordination

COMMUNICATIONS

COMMAND, CONTROL, COMMUNICATIONS, COMPUTERS, AND INTELIGENCE (C4I)

- Establish communication net between all medical units. Identify Net Control.
- Establish communication protocols and reporting requirements.
- Establish backup procedures for communicating between units on the Medical Regulating Net.

COMMUNICATIONS

- NAVAL MESSAGE
- E-MAIL
  NIPERNET(UNCLASSIFIED)
  SIPERNET (CLASSIFIED)
- POTS (Plain old Telephone System)
  LANT POTS (Atlantic)
  MED POTS (Mediterranean)
  IO POTS (Indian Ocean)

TACTICAL COMMUNICATIONS

- MEDREG NET (Flag Plot, TACRON, Combat)
- LF TAC ONE (Landing Force Operations Center-LFOC)
- LF MEDREG NET (TACLOG)
- OTHER- ARG ADMIN, FLEET TAC, ARG COMMAND, FLEET HIGH-SATCOM

PURPOSE OF THE MEDICAL REGULATING NET

- Pass pertinent information and provide a rapid means of communications between the MRCO and all units on the MR Net
- Ensures the MRCO has current information on the capabilities and status of all units on the net
- Should not be used for anything but medical regulating, blood status, and other medical regulating reports

COMPOSITION OF THE MEDICAL REGULATING NET

- Medical Regulating Control Officer
- Evacuation Points
- Casualty Receiving Treatment Ship
- Patient Evacuation Officer/HES/BES
- Beachmaster Unit

MEDICAL REGULATING NET

- Radio Net - Consists of two or more regulating stations operating on the same frequency for the purpose of regulating casualties.
- Net Control Station - Designated by Task Force Commander in conjunction with the CATF Surgeon to direct and control the operation and flow of traffic on the net. Normally the senior command

DUTIES OF NET CONTROL

- Expedite radio traffic
- Maintain circuit discipline and limit extraneous traffic
- Resolve disputes between stations on the net
- Monitor and initiate corrective action for security violations, misuse, etc.

REGULATING NET OPERATING RULES

- Write message down before transmitting
- Keep messages short, concise, consistent
- Speak clearly in natural phrases
- Pause after each phrase
- Listen before transmitting
- Transmit at the speed of the slowest operator

PRACTICES TO AVOID

- Unofficial conversation between operators
- Transmitting on a directed net without permission
- Excessive testing or checking radio
- Transmitting the other operator’s name
- Using unauthorized PROWORDS
- Compromise of classified call signs
- Profane, indecent or obscene language

COMMUNICATIONS ASSISTANCE

- PROWORDS - Pronounceable words or phrases that have been assigned a specific meaning for the purpose of expediting message traffic transmitted via the radio
- PHONETICS - Words designated to represent letters of the alphabet and numerals

TYPES OF MEDICAL REGULATING NETS

- Directed Net - Authorization to transmit information over the net must be requested from the unit designated Net Control Station. All transmissions, except FLASH communications, must be approved.
- Free Net - Transmissions may be sent over the net without requesting permission.

TYPES OF CALLS

- Single Call - One call sign used to call one station.
- Multiple Call - Each call sign refers to one station, but more than one call sign is used.
- Collective Call - One call sign designates more than one station, but not all.
- Net Call - One call sign is used to designate all stations on the net.
- Abbreviated Call - Once initial contact is made, use the PROWORD “This is”.

PRECEDENCE OF CALLS

- FLASH - Prosign Z - Highest precedence, requires **action as fast as humanly possible.**
- IMMEDIATE - Prosign O - Second Highest precedence, requires **action within 1/2 to 1 hour of receipt.**
- PRIORITY - Prosign P - Third highest precedence, requires **action within 1 to 6 hours of receipt.**
- ROUTINE - Prosign R- Lowest precedence, requires **action within 24 hours of receipt.**

SECURITY CLASSIFICATION

- TOP SECRET - Information that could result in **exceptionally grave damage** to national security if released.
- SECRET - Information that could result in **serious damage** to national security if released.
- CONFIDENTIAL - Information that could be **prejudicial** to national security if released.

COMMUNICATIONS SECURITY

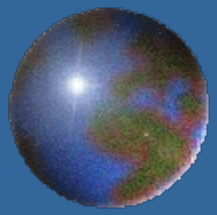
- DO NOT compromise call signs.
- Essential Elements of Friendly Information- Specific information established by the operational commander, which if revealed would degrade the security of operations.

COMMUNICATIONS SECURITY

- Only communications that require rapid transmission to accomplish military objectives are transmitted via the MRN.
- Messages must be short and concise, and be assigned the proper precedence.

ALTERNATE COMMUNICATION NETS

- Medical Battalion Command Net - MED BATT CO to exercise command and control
- Medical Battalion Evacuation Coordination Net - Ground - Evacuation headquarters, ambulances, vehicles and medical facilities
- Marine Air-Ground Task Force Alert Net - Used to publish alerts and pass NBC warnings
- Helicopter Direction - HDC for positive control of outbound helicopters



Medical Intelligence

Show the presentation

NAVY DEPLOYABLE MEDICAL UNITS

ECHELON 1 PLATFORMS

- Surface combatants, submarines, aircraft squadrons
- First aid/emergency medical care
- Emergency medical procedures can be provided by the following personnel:
  - Non medical personnel trained in emergency procedures
  - Hospital Corpsmen/Independent Duty Corpsman
  - General Medical Officer

ECHELON 2 PLATFORMS

- Casualty Receiving and Treatment Ship (CRTS)
  - Minimal ancillary services
  - Whole blood and blood products
  - LHD - Amphibious Assault Ship, Multi-Purpose
  - LHA - Amphibious Assault Ship, General Purpose

ECHELON 3 PLATFORMS

- Fleet Hospital
- Hospital Ship

NAVY FLEET HOSPITAL

- Deployable, pre-positioned unit capable of providing comprehensive medical care
- 500 bed capability
- Assembled in 10 days (By doctrine)
- Provide full resuscitation
- Provide emergency surgery

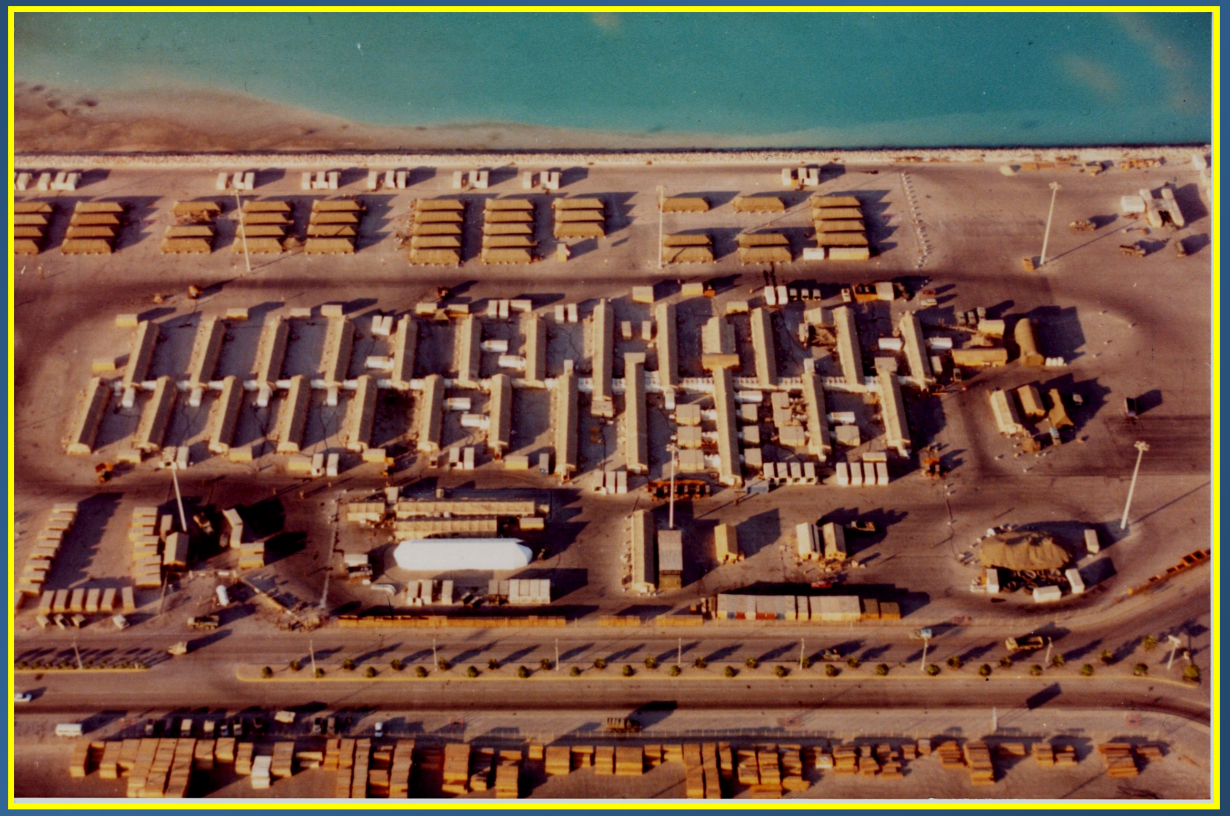
NAVY FLEET HOSPITAL

- Full resuscitative surgery
- Emergency surgery for acutely wounded
- 10 in inventory
- 737 Medical personnel, 241 non-medical
- 3 operating rooms (2 tables each)
- 80 ICU beds
- Laboratory, pharmacy
- X-ray (1 fixed, 1 portable)

NAVY FLEET HOSPITAL

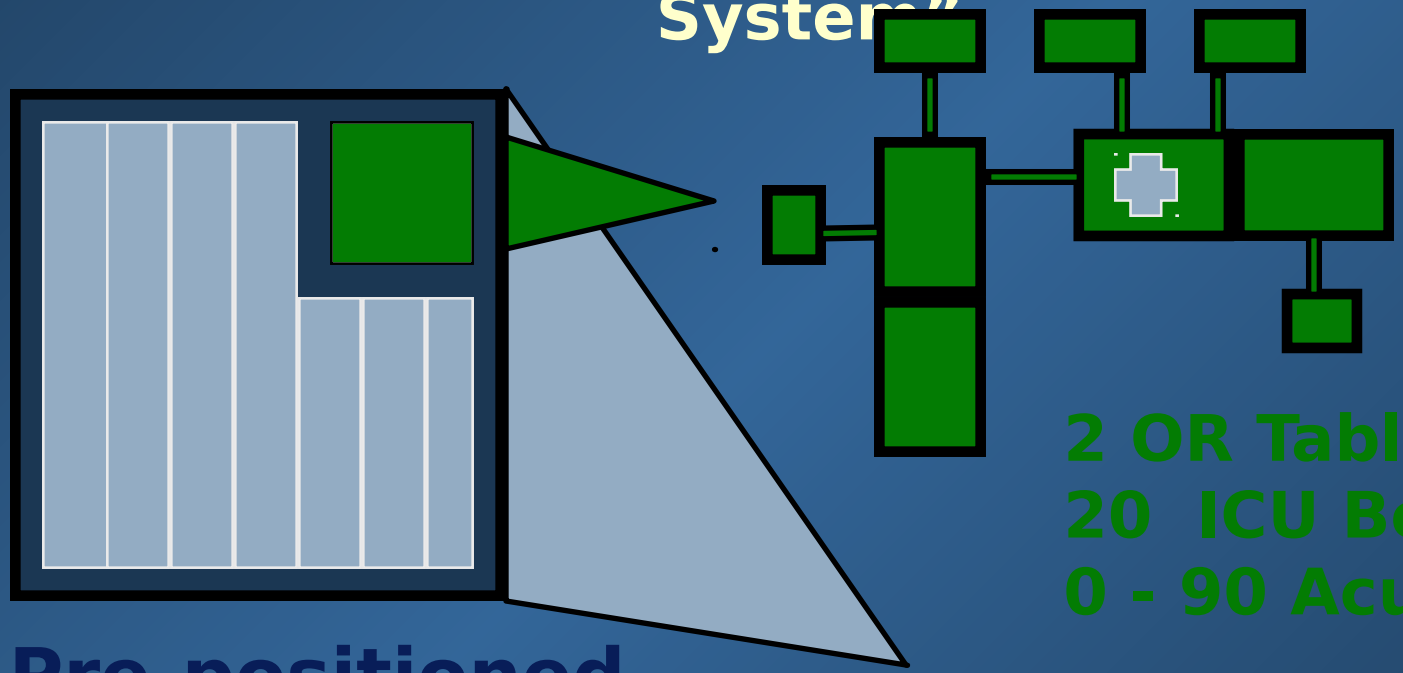
- Six Active Duty - Bremerton, Camp Pendleton, Camp Lejeune, Portsmouth, Jacksonville, and Pensacola.
- Four Reserve - Dallas, Everett, Fort Dix and Minneapolis
- Stored in temperature controlled warehouses in deployable iso containers

NAVY FLEET HOSPITAL



FLEET HOSPITAL RECONFIGURATION

"Naval Expeditionary Medical Support System"



2 OR Tables
20 ICU Beds
0 - 90 Acute Beds

Pre-positioned Warehouse

6 OR Tables
80 ICU Beds
420 Acute Beds

NEMMS FLEET HOSPITAL

LOCATION OF PREPOSITIONED FLEET HOSPITALS

Fleet Hospitals Afloat - MV GREEN RIDGE - (1)

Fleet Hospital Guam - (1)

HOSPITAL SHIP (T-AH)

HOSPITAL SHIP (T-AH)

- A mobile, flexible, rapidly responsive, acutcare facility used to support amphibious naval forces and disaster relief operations
- NCA and CINC assets
- Ship’s Co. Military Sealift Command (60)

HOSPITAL SHIP (T-AH)

- Deploys 1000 beds
- 80 ICU beds, 20 recovery room, 400 intermediate care beds, 500 minimal care for recuperation and recovery
- 12 major operating rooms
- 947 medical personnel
- 267 non-medical

HOSPITAL SHIP HOMEPORTS

USNS MERCY
San Diego, CA
Staffed by NMC San D[illegible]o, CA

USNS COMFORT
Baltimore, MD
Staffed by NNMC
Bethesda, MD

Global Deployability

MOBILE MEDICAL AUGMENTATION READINESS TEAM (MMART)

- Provides rapid, short-term (less than 180 days) medical augmentation for domestic emergencies, low intensity conflicts, and peacetime contingencies
- Configured with a Surgical Team as the nucleus, with other specialty teams providing additional functional support.
- MMART’s are based at CONUS MTFs.
- Replaced by FST’s on routine CRTS deployments.

MMART TEAMS

- Surgical Team
  - Surgical Unit
  - Surgical Support Unit
  - Ancillary Support Unit
- Specialist Support Team
- Humanitarian Support Team
- Special Psychiatric Rapid Intervention Team
- Medical Regulating Team
- Preventive Medicine Team

SPECIAL PSYCHIATRIC RAPID INTERVENTION TEAM (SPRINT)

- Provides short term mental and emotional support immediately after a disaster with the goal of preventing long-term medical psychiatric dysfunction or disability
- TWA Aircraft Crash
- Korean Air 747 crash in Guam
- Haiti Ferry Disaster
- BUDS School Drowning

FORWARD DEPLOYABLE LAB (FDL)

- A portable, rapidly deployable, state of the art laboratory.
- Capable of diagnosing militarily relevant diseases and biological threats.
- Disease risk assessment, diagnosis, surveillance, investigation and identification.
- Components include: core lab, special diagnostic and biological threat agent

FORWARD DEPLOYABLE LAB (FDL

Under OPCON of the Naval Environmental Preventive Medicine Units

Contingency Response Team (CRT)

- OCUNS MTF Assets
- Initial On-site, collection, triage, resuscitation, and staging
- 24 hr rapid response/7 operation
- Typhoons, earthquakes, floods, etc.
- Mission Specific/Not Global
- MMART can augment

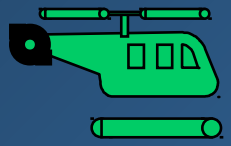
AEROMEDICAL EVACUATION

AEROMEDICAL EVACUATION

- The movement of patients under medical supervision, to and between medical treatment facilities by air transportation

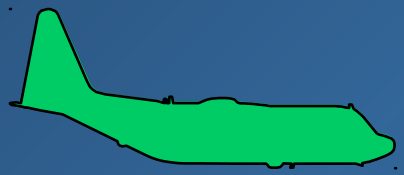
Echelons of Movement (overview)

Echelon I



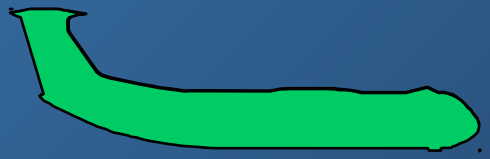
Clear Battlefield

Echelon II-III



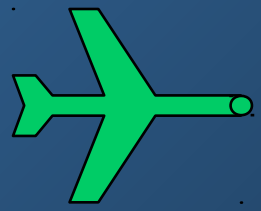
Intra-theater

Echelon IV



Inter-theater

Echelon V



CONUS Distribution

Tactical Evacuation

AEROMEDICAL EVACUATION (AE) SYSTEM

- Control of patient movement by air transport.
- Specialized medical attendants and equipment.
- Facilities on or near air strips and air bases for limited care of in-transit patients.
- Communications with originating, destination, and en-route medical facilities concerning patient transportation.

AEROMEDICAL EVACUATION

- Designated Aeromedical Evacuation - designated tactical, logistic aircraft temporarily equipped and staffed for enroute care
- Dedicated Aeromedical Evacuation Aircraft - dedicated to full time evacuation and permanently equipped and staffed for enroute care

The Army MEDEVAC

FM 8-10-6

Medical Evacuation
In Theater of Operations

Tactics, Techniques, and
Procedures (TT&P)

Medical Evacuation Battalion

- Focuses on C2, planning, Pt Evac, & Vehicle mgt.
- Coordinates EVAC ops & COMM
- Logistics
- Unit level maintenance

Ground Ambulance Company

- Attached to EVAC Battalion
- EVAC 160 litters or 320 Ambulatory
- Movement to ASF’s or MASF’s
- Broke down Platoons and Squads
  - 2 platoons
  - 10 Squads
- The primary means of EVAC

Air Ambulance Company

- Attached to EVAC Battalion
- 24 hr/day operation capabilities
- 15 UH-60A – 6 litter/1 Ambulatory
- 15 UH-1H/V – 6 Litter or 9 Ambulatory
- Know tactical requirements for landing
- Utilize the 9-line MEDEVAC Request

Patient Movement Agencies

- Global Patient Movement Requirements Center (GPMRC)
- Theater Patient Movement Requirements Center (TPMRC)
- Joint Patient Movement Requirements Center (JPMRC)
- Joint Medical Regulating Office (JMRO)

AE COMMAND STRUCTURE

- U. S. Transportation Command, Scott AFB
- Global Patient Movement Requirements Center (GPMRC), Scott AFB
- Theater Patient Movement Requirements Center (TPMRC)
- Medical Regulating Control Center (MRCC)

GLOBAL PATIENT MOVEMENT REQUIREMENTS CENTER (GPMRC)

- Subordinate command of the U.S. Transportation Command
- Primary point of contact for world wide regulating and evacuation of patients
- Coordinate with Theater Patient Movement Requirements Centers
- Coordinate and allocate aircraft and bed assets to all theaters of operation

GLOBAL PATIENT MOVEMENT REQUIREMENTS CENTER (GPMRC)

- Monitor execution of patient movement missions.
- Manager for policy implementation, information system support, and standardizing procedures.

AIR MOBILITY COMMAND

USTRANSCOM

Provides strategic Airlift and logistical support to the Operating Forces, including Medical Evacuation.

Primary Aircraft -- LITTER/AMB.

C-141 STARLIFTER	103	147
C-9 NIGHTENGALE	40	40
C-130 HERCULES	50	27

THEATER PATIENT MOVEMENT REQUIREMENTS CENTER (TPMRC)

- Incorporate CINC guidance into evacuation planning.
- Receive and validate patient movement requests.
- Analyze and plan patient movement within the constraints of actual assets.
- Transport patients, by air, under medical supervision from forward airfields in the AOA to points of definitive medical care either in the AOA or out of the AOA.

MEDICAL REGULATING CONTROL CENTER (MRCC)

- Operational agency established by the Task Force Commander
- Primary function is to regulate patients from echelon 2 to echelon 3 and between echelon 3 facilities in the AOA
- Control the medical regulating net
- Monitor patient loading and adjust as necessary

PATIENT STABILITY

- Stabilized within the capabilities of the originating MTF.
- Clinical stability may be the reason the patient is being moved to a higher echelon facility.
- Patients moved from Echelon 1, 2, or 3 may not be clinically stable due to the severity of their wounds, condition, limited resources, and time constraints.
- Prior to patient movement, a patient’s airway must be established, fractures splinted, hemorrhage controlled, and shock treated.

PATIENT PREPARATION FOR ROUTINE MEDEVAC

- All MEDEVAC patients must have:
  - Money, Money, Money, Money
  - Funded TAD Orders
  - Health Records
  - ID Card
  - Personnel Effects
  - All required medications - enough for 7 days
  - All consumable supplies - enough for 7 days

Priorities of Patient Movement

- 1 Urgent Emergency intervention to save life, limb or sight
- 2 Priority Specialized treatment not available locally
- 3 Routine Treatment available locally, but patient would benefit from being moved
- 4 Admin Evacuated for medical convenience

Patient Movement Items (PMIs)

- Medical equipment & supplies
- PMI exchange (send someone w/ pt)
- Addressed in the OPLAN
- Originating MTF provides PMI
- Remain with Pt until arrival

EQUIPMENT RESPONSIBILITIES

- Requesting MTF Provides:
  - Ventilator
  - Cardiac Monitor
  - Pulse Oximeter/Supplies
  - Stryker Frames
  - Other Reusable Items
  - Consumable Supplies/Medications
  - Medical Attendants
- AE System Provides:
  - Oxygen Analyzer
  - Suction
  - *Cardiac Monitor
  - *Pulse Oximeter

* Used for in-flight emergencies only

No one is resourced to provide these items

AF is considering changes and assuming responsibility

EUROPEAN THEATER

86 AES

Ramstein AB Germa

C-9 Airframes: 4

14 AE Crews

PACIFIC THEATER

374 AES

Yokota Japan
C-9 Airframes: 3
15 AE Crews

CONUS

375th AES

Scott AFB IL

C-9 Airframes:

23 AE Crews

THEATER AEROMEDICAL EVACUATION SYSTEM (TAES)

- Limited capability for in-flight care without augmentation
- Limited patient information available
- Basic supportive care available to stable patients
- Limited comfort items (latrines, special diets)
- Major invasive procedures inappropriate
- No physician routinely onboard
- Does not perform “door to door” service

THEATER AEROMEDICAL EVACUATION SYSTEM (TAES)

- The TAES is not
  - A medical treatment facility
  - A ground ambulance service
  - A passenger transport service
  - Normally staffed with a physician
  - Re-supply source
  - The patient regulating agency

TAES ESTABLISHMENT

- TAES assets are developed on the building block principle
- Select only unit type codes required in OPLAN
- Each developed to support specific mission
- Equipped for austere but adequate conditions
- Concept is to “buy only what is needed” to support mission

TAES OPERATIONAL CAPABILITIES

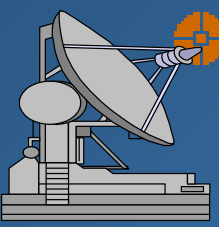
- AE mission support elements can be deployed to a forward operating location with forward medical elements and to an airstrip at a forward operating base.
- AE crew members (CCAT) can support AE missions as far forward as C-130 aircraft are approved to operate.

AEROMEDICAL EVACUATION ADVANCED ECHELON TEAM (ADVON)

- 8 Personnel
- Deploy in advance of AE command and control elements to arrange required TAES support.
- Advises the CATF regarding AE support requirements.
- Assumes initial operational command and control, provides communications for TAES.

AE CONTROL CENTER (AECC)

- 19 Personnel
- Radio Operators
- Provides operational control and communications network control for TAES
- Coordinate AE airlift requirements with MTF’s and other medical command elements
- Requires full base support, 10,000 sq. ft. for antennas and a fuel supply



AE OPERATIONS TEAM (AEOT)

- 32 personnel
- Provide operational control and mission management at airbases supporting AE.
- Manages AE air crews, equipment, and launch and recovery of AE missions.
- Supervises ground handling and on/off loading equipment and AE kits.

AE LIAISON TEAM (AELT)

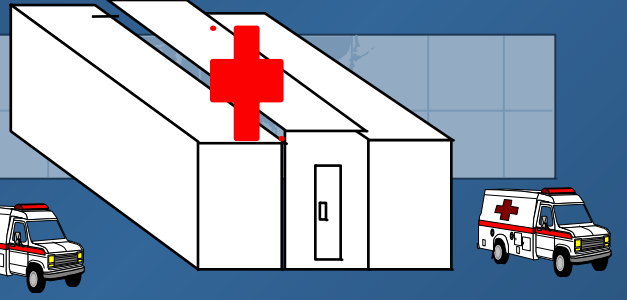
- 6 Personnel
- Communications link between the MTF and AECC.
- Stationed with MTF to coordinate patient movement requirements. (co-located w/Surg. Co)
- Reports special equipment and attendant requirements.
- 2 MSC’s, 1 Flight Nurse, 3 radio operators to help with patient preparation.

AEROMEDICAL EVACUATION CREW

- 5 Personnel: 2 Flight Nurses, 3 Aeromedical Technicians.
- Control and monitor patient onload and offload.
- Provides in-flight supportive nursing care.
- Physicians not part standard crew.
- Tailored to meet patient support requirements.

MOBILE AEROMEDICAL STAGING FACILITY (MASF)

- 39 Personnel
- Mobile, tented, temporary staging facility
- Provides 4 - 6 hours of patient holding at forward airfield
- Staffed for 50 patients - 4 cycles per day
- No organic beds, uses MTF provided litters
- Supportive nursing care, no special

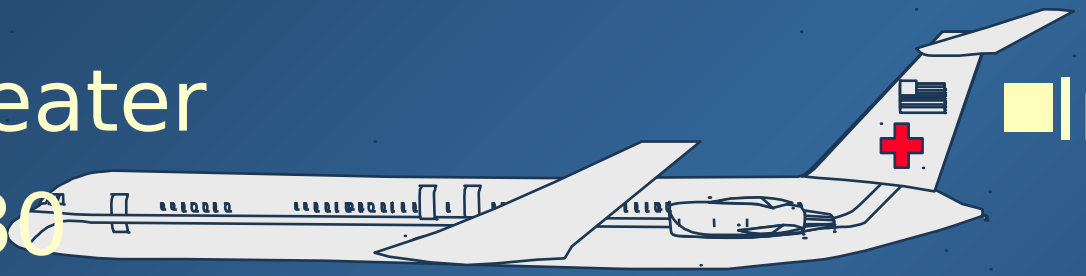


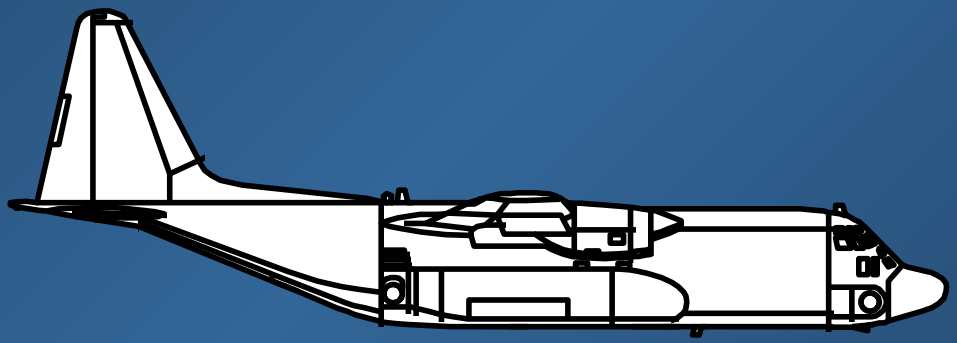
AEROMEDICAL STAGING FACILITY (ASF)

- 36 - 179 Personnel
- 50 to 250 beds, using 50 bed increments.
- Located at strategic interface airfields, non- mobile.
- Cots and beds for overnight patient holding
- Staffed with Flight Surgeons.
- Critical care patients require hospital support.

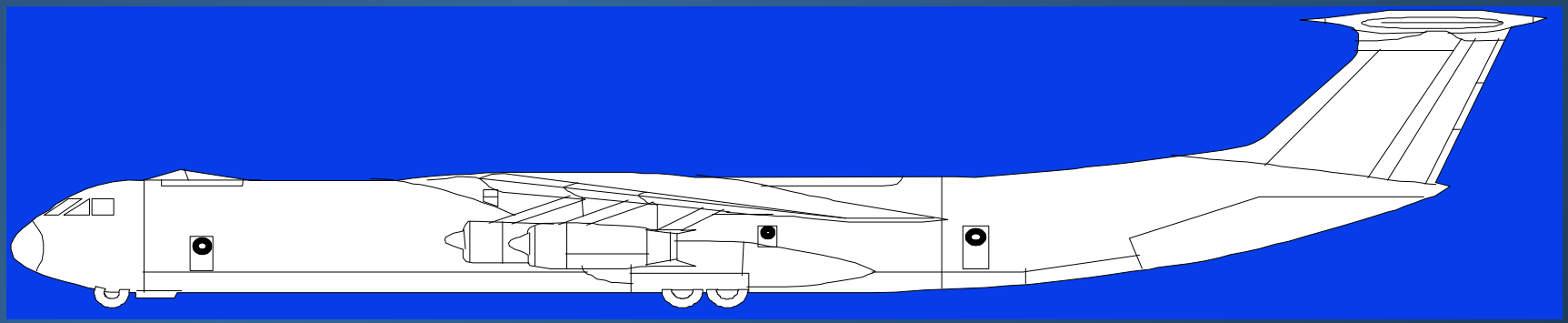
PRIMARY AIRCRAFT USED IN AE

- Intratheater
  - C-130
  - C-9A
  - C-27

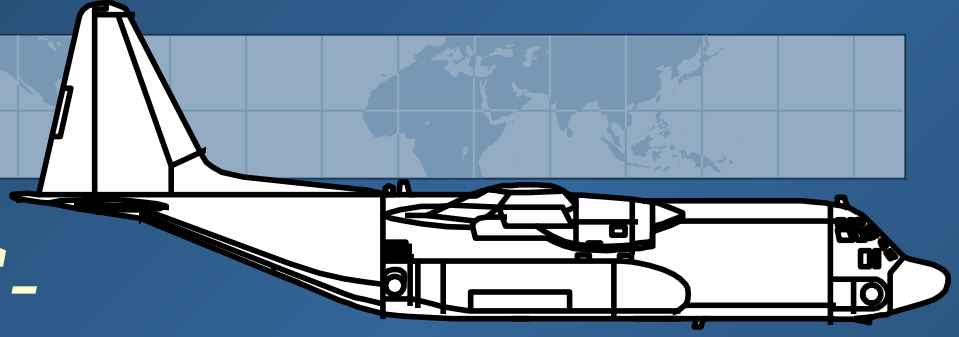




- Intertheater
  - C-141
  - B-767 (Contingency



AEROMEDICAL EVACUATION C-130

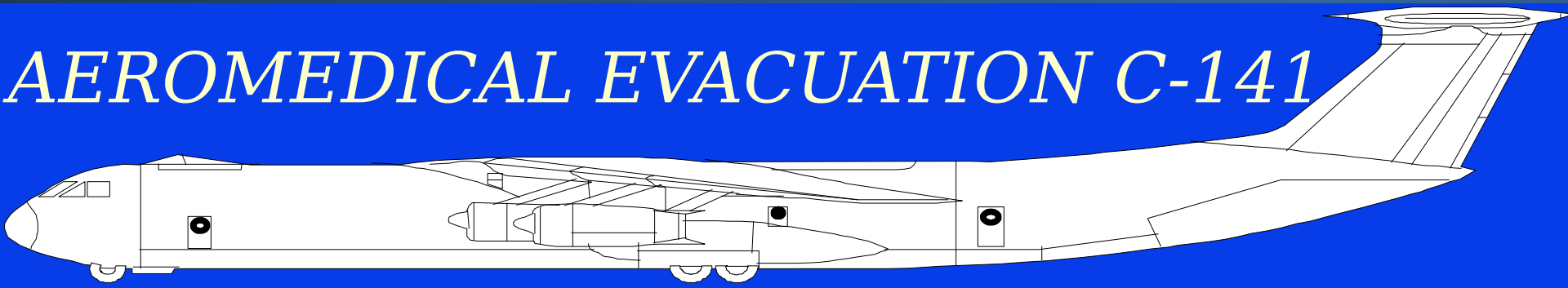


- Contingency and peacetime support
- 50 litter patients, 27g factor - 74 maximum
- Integral litter configuration equipment
- Requires carry-on oxygen and electrical power conversion for 110 VAC/60 HZ
- Can operate for AE as far forward as is routinely used to resupply forward elements

AEROMEDICAL EVACUATION C-9A

- Only dedicated AE aircraft
- Serves in all three theaters
- Studying options for upgrade and replacement
- C-130 / B-767 Augments for CONUS
- Planning factor is 40 patients

AEROMEDICAL EVACUATION C-141



- Current workhorse for strategic AE
- Aging, restricted fleet
- Litter capacity of 32 or 48 with fleet mod
- With additional equipment, can accommodate 103 litters
- Planning factors: 60 retrograde / 90 dedicated
- Requires electrical converter for 110 VAC/60HZ
- Integral oxygen available
- C-17 (when available) provides reduced capability

AEROMEDICAL EVACUATION KC-135 / KC-10

- Opportune for strategic AE
- Carry on oxygen
- Requires electrical converter for 110 VAC/60HZ
- Pursuing establishing integral 24 litter capability and electrical interface for KC-135

CIVILIAN RESERVE AIR FLEET (CRAF)

- Provides dedicated AE capability through Civil Reserve Air Fleet Program.
- Only activated by Presidential order.
- Once configured by contractor, AE ship sets provide organic litter, oxygen, and electrical capability to each litter position
- Provides crew work stations.
- Working with CRAF Program Managers to identify “optimum” number of AE CRAF needed.

AIRLIFT RESOURCES DETERMINATION

- Retrograde AE Missions
  - Maximizes use of CINC apportioned/allocated airlift
  - Limits selection options
  - Requires ground time to configure aircraft
  - Reduces patient carrying capacity
- Dedicated AE Missions
  - Can be adjusted easier to meet demands
  - Requires fewer resources
  - Removes aircraft from logistics flow

GENEVA CONVENTION PROTECTION

- Notify enemy of routing, schedule, patient load
- Cannot use aircraft to carry “war” materials
- Dedicated to AE or AE related support
- Above provisions normally preclude marking military Aircraft other than C-9A or CRAF

VISION FOR CHANGE

- Seamless patient transportation from point of injury through definitive care.
- Patient in-transit visibility throughout the experience.
- System flexibility to meet contingency and peacetime responsibilities.

GLOBAL COMMAND AND CONTROL

- TRAC2ES - Transcom Regualting and Command and Control Evacuation System

- Global C2 system with integration of separate Medical Regulating and Aeromedical Processes (DoDD 5154.6 and DoDI 6000.11)

TRANSCOM REGULATING AND C2 EVACUATION SYSTEM (TRAC2ES)

- Replaces DMRIS
- New or refined functionality.
- DMRIS and APES functionality in EUCOM.
- Provide plan and schedule for hardware and software implementation in PACOM.

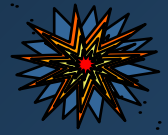
TRANSCOM REGULATING AND C2 EVACUATION SYSTEM (TRAC2ES)

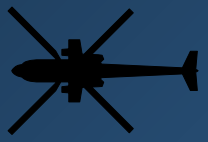
- Delivers patient tracking capability to an austere environment requiring positive control of patient regulating, evacuation and asset visibility.
- Deployment plan - Modify TRAC2ES software to work with CHCS.
- Insert TRAC2ES capability onto medical communications backbone.
- Operational Testing in EUCOM.

PATIENT PREPARATION FOR ROUTINE MEDEVAC

- All MEDEVAC patients must have:
  - Money, Money, Money, Money
  - Funded TAD Orders
  - Health Records
  - ID Card
  - Personnel Effects
  - All required medications - enough for 4 days
  - All consumable supplies - enough for 4 days

THEATER AEROMEDICAL EVACUATION SYSTEM PATIENT MOVEMENT

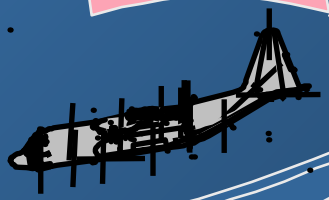


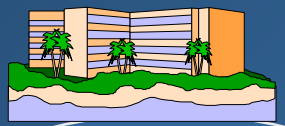


Battlefield

STP/SURG CO
AELT

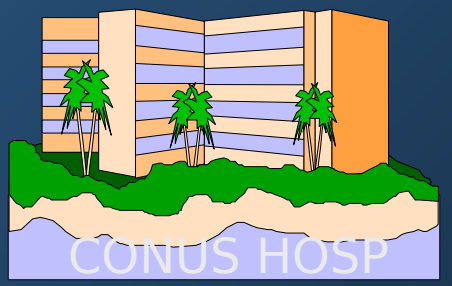
MASF/FLEET HOSP
AELT





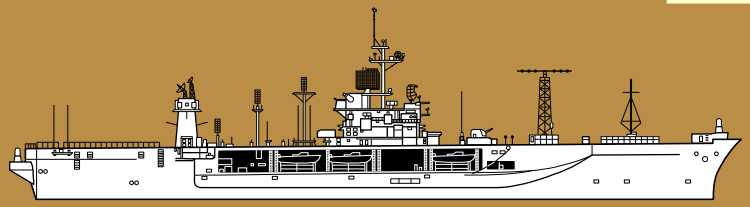
AEOT/ASF
OCONUS MTF

FINAL DESTINATION

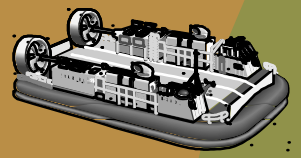


CONUS HOSP

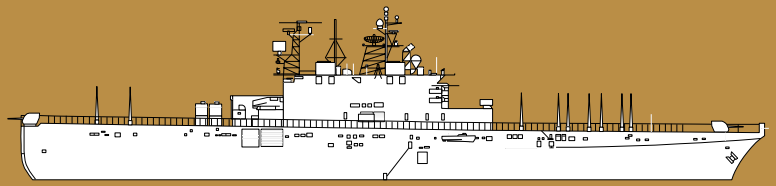
AREA OF OPERATION



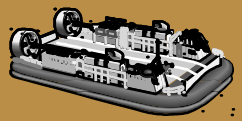
Flagship
Medical Regulating Control Officer

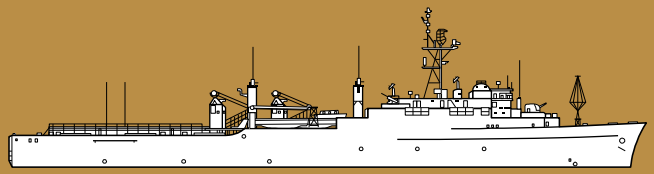


LCAC



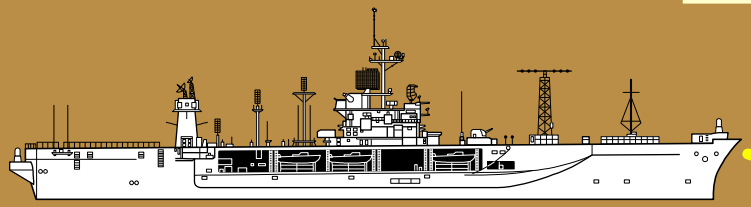
Casualty Receiving and Treatment Ship
Medical Regulating Team



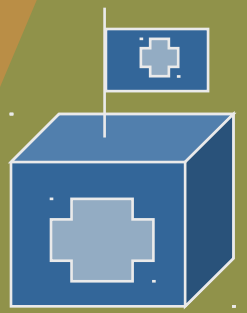


Primary Control Ship
Medical Regulating Team

AREA OF OPERATION

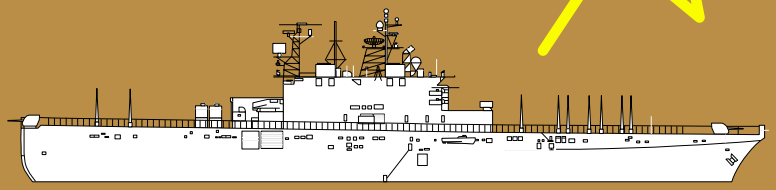


Flagship ·
Medical Regulating
Control Officer

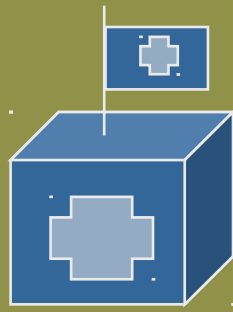


EVAC
STATION

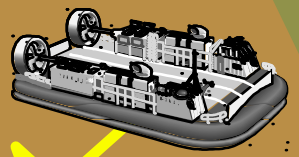
LZ



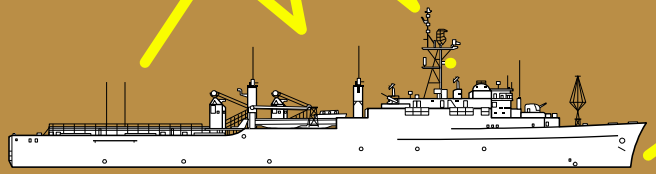
rimary Casualty Receiving
and Treatment Ship
Medical Regulating Team



BAS

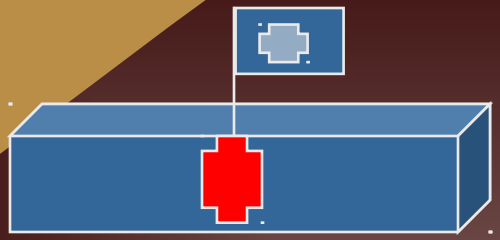


LCAC



Primary Control Ship
Medical Regulating Team

AREA OF OPERATION



LZ

Fleet Hospital

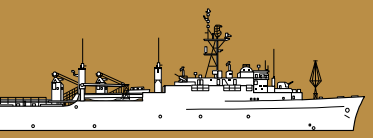
LZ

Battalion
Aid
Station

CSSE/CSSA

Surgical Company

STP



Front
Line

Naval Hospital

Fleet Hospital

Comfort

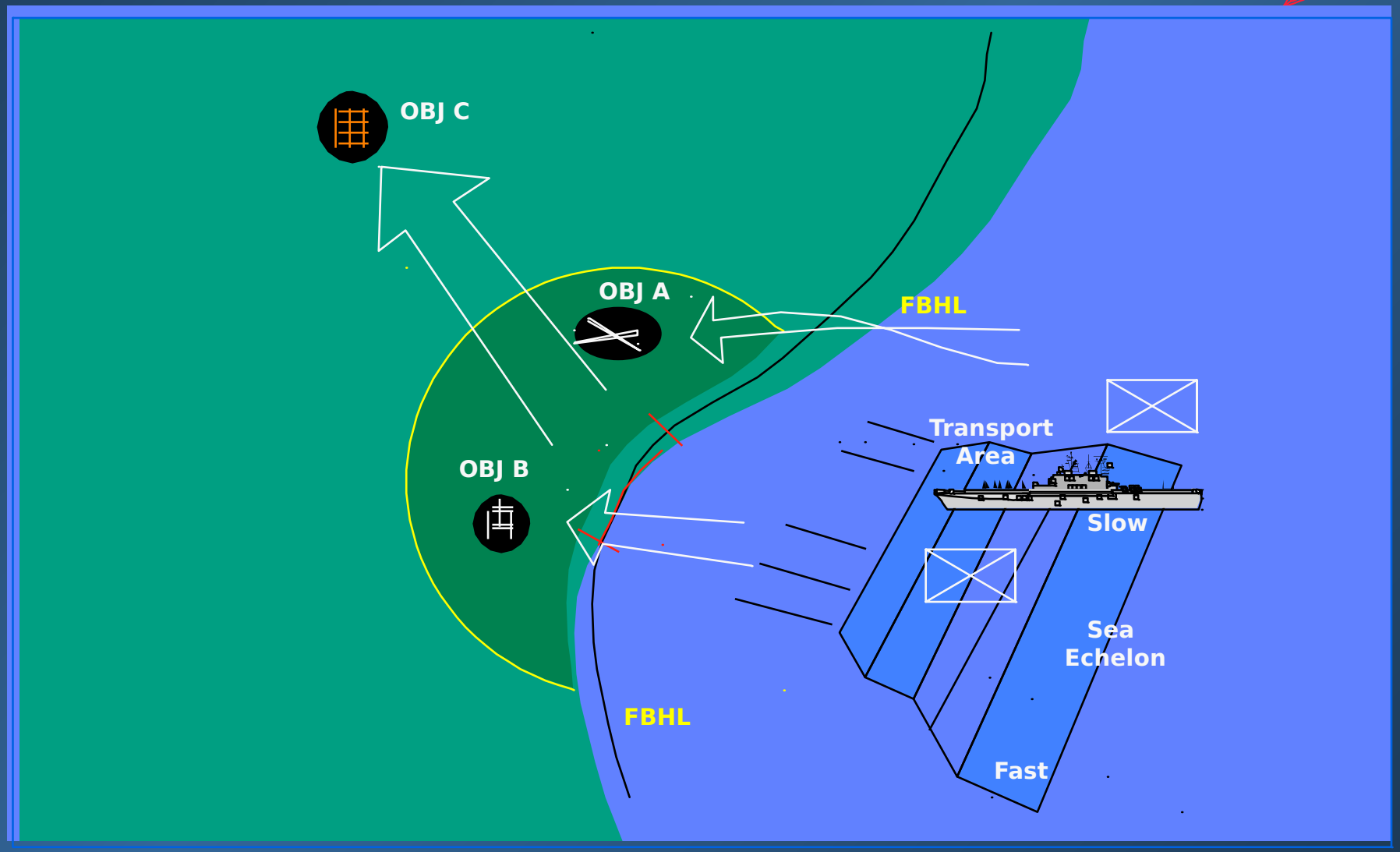
insertion

BES, BAS, STP

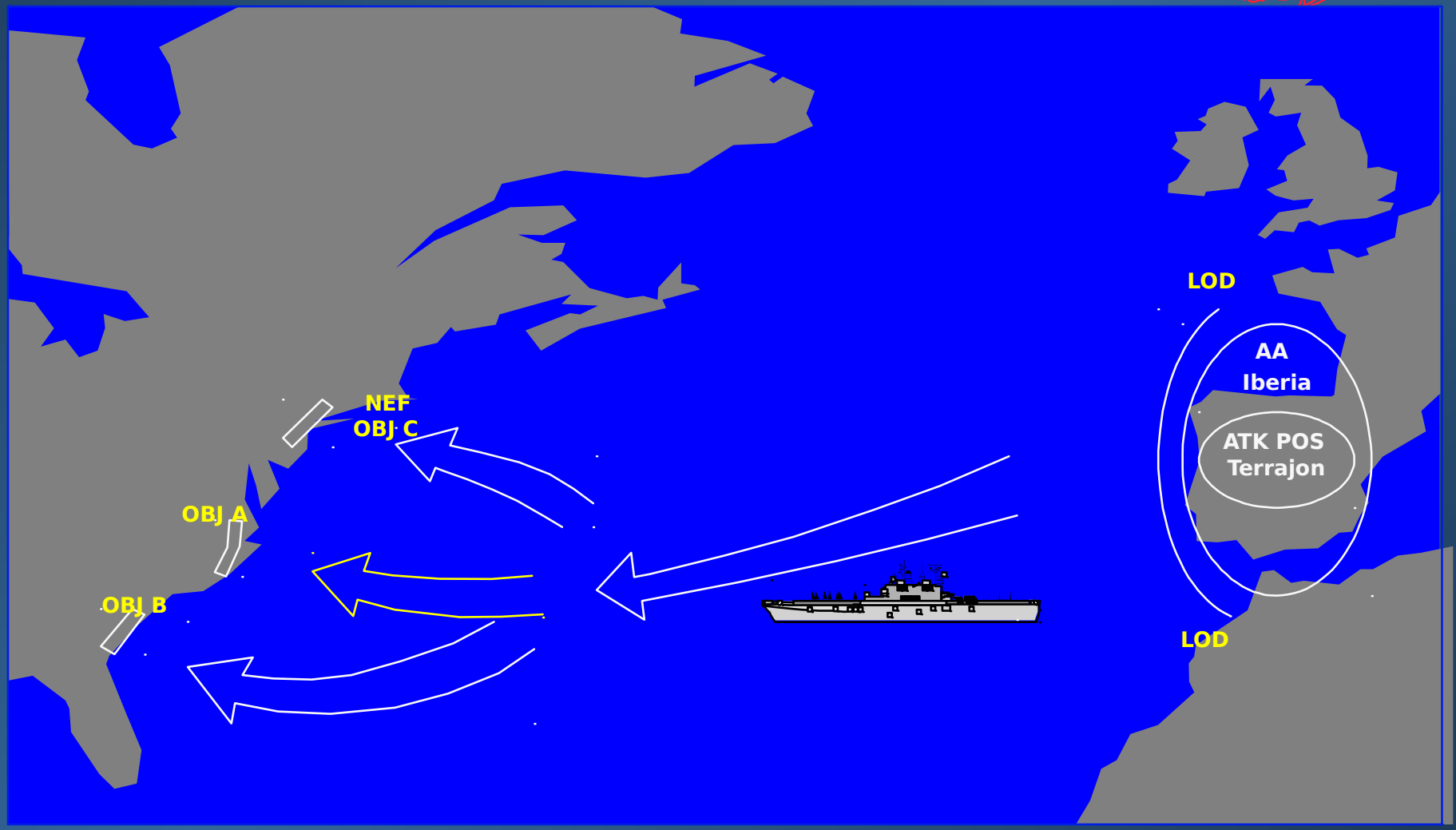
KEARSARGE

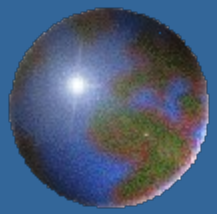
Surgical Company

THE WAY WE ARE



THE WAY WE NEED TO BE





The Toys

REENGINEERING MEDICAL CARE FOR THE 21st CENTURY

- FFRSS - Advanced Surgical Suite for Trauma Casualties
- Combat Medic Vest - Not So Good
- Digital Information Device - MARC Card
- JMOT
- TMIP

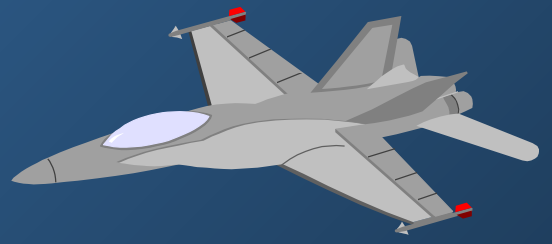
Technology/Informatics

NO
YES
MAIN MENU:
ASSESSMENT
›TREATMENT
CONDITION
DISPOSITION
REASSESS
HELP/SHOW
10/31 1000Z
MEDTAG

MEDTAG
LIGHT
NO
YES

KEYS FOR SUCCESS!!

- Integrate yourself within your command.
- Understand Command Relationships.
- Communicate “At all levels”
- FOLLOW THE (AOR) GUIDANCE SIXTHFLT and FIFTHFLT……..
- Common sense, creativity, & drive
- Most importantly “HAVE FUN”



QUESTIONS ??
Patient Movement Time